

LAW COMMISSION OF INDIA

196<sup>TH</sup> REPORT

ON

MEDICAL TREATMENT TO TERMINALLY ILL  
PATIENTS (PROTECTION OF PATIENTS  
AND MEDICAL PRACTITIONERS)

MARCH, 2006

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28<sup>th</sup> April, 2006

***Dear Shri Bhardwaj ji,***

This 196<sup>th</sup> Report of the Law Commission on ‘Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)’ is one of the most novel, interesting and important subjects ever undertaken by the Law Commission of India for a comprehensive study.

The request for a study on this subject came from the Indian Society of Critical Care Medicine at a Seminar on 27<sup>th</sup> April, 2005, which was inaugurated by Hon’ble Minister for Law and Justice. The Commission agreed to study and give a Report as well as a draft Bill.

So little is known in our country about the law applicable to terminally ill patients (including patients in persistent vegetative state) who desire to die a natural death without going through modern Life Support Measures like artificial ventilation and artificial supply of food.

Indeed almost everybody has been asking the Commission if this Report is for the purpose of legalizing ‘Euthanasia or Assisted Suicide’. We have, therefore, started the first paragraph of our Report in Chapter I with the following words:

“The title to this Report immediately suggests to one that we are dealing with ‘Euthanasia’ or ‘Assisted Suicide’. But we make it clear at the outset that Euthanasia and Assisted Suicide continue to be unlawful and we are dealing a different matter ‘with-holding Life-

Support Measures’ to patients terminally ill and, universally, in all countries, such withdrawal is treated as ‘lawful’”.

While ‘Euthanasia’ is an act of any person, including a doctor, of intentionally killing a person who is terminally ill by giving drugs, ‘Assisted Suicide’ is an act of the patient who receives the assistance of a doctor and takes a drug with the intention of committing suicide. They are unlawful as held by our Supreme Court in Gian Kaur vs. State of Punjab: 1996(2) SCC 648 and will continue to be unlawful.

A hundred years ago, when medicine and medical technology had not invented the artificial methods of keeping a terminally ill patient alive by medical treatment, including by means of ventilators and artificial feeding, such patients were meeting their death on account of natural causes. Today, it is accepted, a terminally ill person has a common law right to refuse modern medical procedures and allow nature to take its own course, as was done in good old times. It is well-settled law in all countries that a terminally ill patient who is conscious and is competent, can take an ‘informed decision’ to die a natural death and direct that he or she be not given medical treatment which may merely prolong life. There are currently a large number of such patients who have reached a stage in their illness when according to well-informed body of medical opinion, there are no chances of recovery. But modern medicine and technology may yet enable such patients to prolong life to no purpose and during such prolongation, patients could go through extreme pain and suffering. Several such patients prefer palliative care for reducing pain and suffering and do not want medical treatment which will merely prolong life or postpone death.

Unanimity among Courts in all countries on certain legal principles:

The House of Lords in Airedale NHS Trust vs. Bland: 1993(1) All ER 821 (HL), the American Supreme Court in Cruzan vs. Director MDH (1990) 497 US 261, the Irish Supreme Court in Ward of Court, Re a : 1995 ILRM 401, the Court of Sessions, Inner House of Scotland in Law Hospital NHS Trust vs. Lord Advocate: 1996 SLT 848, the Canadian Supreme Court in Ciarlariello vs. Schater 1993(2) SCR 119 and in Rodriguez vs. The Attorney General of Canada 1993(3) SCR 519, the Australian Courts in Q vs. Guardianship Administrative Board & Pilgrim: 1998 V.S. (CA) and Northridge vs. Central Sydney Area Health Service: (2000) NSW 1241 (SC), Issac Messiha vs. South East Health: 2004. NSW (SC) 1061 and the

New Zealand Court in Auckland Area Health Board vs. Attorney General: 1993(1) NLLR 235, to name a few, are unanimous on the legal principles.

Competent patient: (Informed decision):

Every terminally ill who is a competent patient has a right to refuse treatment and the decision is binding on the doctors provided the decision of the patient is an 'informed decision' (i.e., the decision is taken by the patient who has been informed about (i) the nature of his or her nature, (ii) any alternative form of treatment that may be available, (iii) the consequences of these forms of treatment and (iv) the consequences of remaining untreated). Where a 'competent patient' takes an 'informed decision', when he or she is terminally ill, not to receive medical treatment, such a decision is binding on the doctors and if, contrary to that, any invasive treatment is given it amounts to battery and if further the patient dies, it may even amount to murder. Where a 'competent patient' takes an 'informed decision' to allow nature to have its course, he is, under common law, not guilty of 'attempt to commit suicide' (under sec. 309, Indian Penal Code, 1860), nor is the doctor who thereby omits to give treatment, guilty of abetting suicide under sec. 306 or of culpable homicide under sec. 299 read with sec. 304 of the Indian Penal Code.

Incompetent patients and competent patients who have not taken informed decision:

On the other hand, according to the same case law, in the matter of incompetent patients and also competent patients who have not taken informed decisions, the doctor can take a decision to withhold or withdraw medical treatment, if that is in the 'best interests' of the patients and if it is based on the opinion of a body of medical experts. A 'competent patient' is proposed to be defined as a patient who is not an 'incompetent patient'.

An 'incompetent patient' is proposed to be defined as being a minor or person of unsound mind or a person who is unable to

- (i) understand the information relevant to an informed decision about him or her medical treatment;
- (ii) retain that information;
- (iii) use or weigh that information as part of the process of making his or her informed decision;

- (iv) make an informed decision because of impairment of or a disturbance in the functioning of his or her mind or brain; or
- (v) communicate his or her informed decision as to the medical treatment,

Such patients are not competent to take 'informed decisions' about withholding or withdrawing medical treatment.

As stated above, in the case of such 'incompetent patients' who are suffering from terminal illnesses as also in the case of 'competent patients' who, the doctor is satisfied, have not taken an informed decision, the doctor can, - and this is well-settled law today - take a decision to withhold or withdraw medical treatment in the 'best interests' of the patients if that is the view of a body of experts. This principle is based on the Bolam test. 'Best interests', according to decided cases are not confined to medical interests but include 'ethical, social, moral, emotional and welfare considerations'.

Director General of Health Services and Directors of Medical Services to prepare panel of experts:

In order that these principles and procedures are properly applied with care and are not abused, the Law Commission has recommended several safeguards or conditions to be met in the case of 'incompetent patients' and 'competent patients' who have not taken informed decisions. It is proposed that the doctors must, in the case of patients of these two categories, consult three medical experts from a panel prepared by a Statutory Authority.

Expert opinion of panel mandatory:

Withholding and withdrawal of medical treatment by a doctor in the best interests of such patients referred to in the last paragraph, is permitted only if that course is considered to be appropriate by a body of three medical experts empanelled by the Director General of Health Services for Union Territories and Directors of Medicine (or equivalent authorities) for the States, selected from the panel by the attending medical practitioner.

Maintenance of Register by medical practitioners mandatory:

In addition, it is proposed that, in the case of competent as well as incompetent patients, a Register must be maintained by doctors who propose withholding or withdrawing treatment. The decision as well as the decision-making process must be noted in the Register. The Register to be maintained by the doctor must contain the reasons as to why the doctor thinks the patient is competent or incompetent, as to why he thinks that the patient's decision is an informed decision or not, as to the view of the experts the doctor has consulted in the case of incompetent patients and competent patients who have not taken an informed decision, what is in their best interests, the name, sex, age etc. of the patient. He must keep the identity of the patient and other particulars confidential.

Patient, parents or relatives must be informed:

Once the above Register is duly maintained, the doctor must inform the patient (if he is conscious), or his or her parents or relatives before withdrawing or withholding medical treatment.

In case the patient, parents or relatives want to move the High court under section 14, the medical practitioner shall postpone such withholding or withdrawal for a period of fifteen days and if he does not receive any orders from the High Court, he may then proceed with the withholding or withdrawal.

Copy of contents of Register regarding each patient to be sent to statute named Authority:

A copy of the contents of the Register in regard to each patient who is terminally ill, containing all the details as stated above and the decisions taken must be simultaneously communicated by the doctor to the Director General of Health Services or Director of Medical Services (as the case may be) and acknowledgement obtained. The said authorities must also keep the information confidential.

Medical Council guidelines to be followed:

The doctors and experts must also act in consonance with any guidelines prescribed by the Medical Council of India.

Summary of safeguards in case of incompetent patients and patients who have not taken informed decision:

These safeguards can be summarized as follows:

- (1) No decision will be taken by a medical practitioner to withhold or withdraw medical treatment to a terminally ill patient unless, as required by the Bolam test, he has obtained the expert opinion of a body of three experts, who are experts in relation to the particular illness of the patient and in the matter of critical care.
- (2) Such experts cannot be selected by the doctor at random or at his discretion from those in the profession but must be selected by him out of panel of experts prepared and published by the Director-General of Medical Services for Union Territories and the Directors of Medicine (or other authorities holding equivalent posts) in the States. Such panels must consist of experts in various branches of medicine and critical care and must have minimum experience of 20 years and must be of good reputation. These panels must be published in the appropriate Gazette and on the respective websites for easy access. Those against whom disciplinary proceedings are pending or have been found guilty of professional misconduct will have to be excluded from such panels. In case of difference of opinion among the three experts, majority opinion prevails. It is from such a panel that the doctor must select three experts and go by their opinion.
- (3) Every medical practitioner who takes a decision to withhold or withdraw medical treatment must maintain a register giving details as to why he is or is not satisfied that a patient is competent and as to why he considers the patient has or has not taken an informed decision, as to the opinion of the experts from the panel; the age, sex, address of the patient and what is in the best interests of the patient and other particulars. The information will have to be kept confidential.
- (4) The medical practitioner has to inform the patient (if he is conscious) or parents or relatives about his decision to withhold or

withdraw treatment and if they desire to move the High Court, he has to wait for 15 days and if no orders are received from the High Court, he can proceed.

- (5) A copy of the contents of the register relating to each such patient shall be lodged, as a matter of information, with the Director General of Health Services or Director of Medical Sciences, as the case may be, immediately on the taking of a decision to withhold or withdraw treatment and an acknowledgement therefor will have to be obtained. The above authorities will also have to keep the information confidential.

Only if above safeguards are followed, decision of doctors to withhold or withdraw medical treatment will be treated as lawful:

If the above procedures are followed, the medical practitioner can withhold or withdraw medical treatment to a terminally ill patient. Otherwise, he cannot withhold or withdraw the treatment. More importantly, he will be entitled to the benefits of the provisions of the Act which deem such withholding or withdrawal as 'lawful', only if the provisions of the Act have been followed by him. If the safeguards are not followed, the medical practitioner is not entitled to the above benefit and can be proceeded against in a civil or criminal action. We have, in this context, examined the provisions of sec. 299, sec. 306 and sections 76, 79, 81, 88 and other provisions of the Indian Penal Code, 1860.

Provisions enabling the High Court (Division Bench) to grant declarations or issue directions expeditiously:

Court declarations as to 'lawfulness' of the proposed action of a doctor are common in several countries. In UK and common law countries, there is a procedure enabling patients, parents or relatives or next friend or doctors or hospitals to approach a court of law for a declaration that the proposed action of withholding or withdrawing medical treatment from critically ill patients is 'lawful' in the circumstances because it is in their best interests. The patient, parents or relatives can also move the Court for a declaration that the medical treatment be continued or be withheld or withdrawn. This procedure is intended to enable courts to lay down precedents as to what is 'good medical practice' and once such precedents are available, it may indeed be not necessary to rush to the Court in every

case. In fact, such ‘best medical practices’ laid down by Courts in the UK and Commonwealth countries have now crystallized into various legal principles which we have incorporated in the proposed draft Bill.

We have therefore thought it fit to provide an enabling provision under which the patients, parents, relatives, next friend or doctors or hospitals can move a Division Bench of the High Court for a declaration that the proposed action of continuing or withholding or withdrawing medical treatment be declared ‘lawful’ or ‘unlawful’. As time is essence, the High Court must decide such cases at the earliest and within thirty days. In UK, decisions are sometimes made within half an hour if there is grave urgency and reasons are given later. Such speedy procedure has to be followed because Courts are dealing here with life and death situations.

Once the High Court gives a declaration that the action of withholding or withdrawing medical treatment proposed by the doctors is ‘lawful’, it will be binding in subsequent civil or criminal proceedings between same parties in relation to the same patient. This provision is intended to prevent harassment of doctors and hospitals as stated by Thomas J in New Zealand.

In the Bill, we made it clear that it is not necessary to move the High Court in every case. Where the action to withhold or withdraw treatment is taken without resort to Court, it will be deemed ‘lawful’ if the provisions of the Act have been followed and it will be a good defence in subsequent civil or criminal proceedings to rely on the provisions of the Act.

Confidentiality:

It is internationally recognized that the identity of the patient, doctors, hospitals, experts be kept confidential. Hence, we have proposed that in the Court proceedings, these persons or bodies will be described by letters drawn from the English alphabet and none, including the media, can disclose or publish their names. Disclosure of identity is not permitted even after the case is disposed of.

Guidelines to be issued by Medical Council of India:

The Medical Council of India must prepare and publish Guidelines in respect of withholding or withdrawing medical treatment. The said Council may consult other expert bodies in critical care medicine and publish their guidelines in the Central Gazette or on the website of the Medical Council of India. These guidelines can be modified from time to time.

Advance Medical Directives and Medical Powers of Attorney to be void:

We have proposed that Advance Medical Directives (Living Wills) and Medical Powers of Attorney be of no effect and shall be deemed void inasmuch as they can be easily abused and create unwanted litigation. We have given elaborate reasons in this behalf in Chapter VII.

These are our basic recommendations in the draft Bill which is annexed to the Report.

The Report contains vast literature, both case law and statutes of several countries, UK, USA, Canada, Australia and its States, New Zealand, South Africa and other countries. A special feature of the Report is that the case law is given extensively with medical facts and the medical decisions which have been taken, so that legislators, lawyers, judges, doctors and all others may understand the international trends and the uniformity in all countries in the basic principles applicable.

Yours sincerely,

(M. Jagannadha Rao)

Sri H.R. Bhardwaj  
Union Minister for Law and Justice  
Government of India  
Shastri Bhawan  
NEW DELHI.

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## Chapter – I

### Introductory

The title to this Report immediately suggests to one that we are dealing with ‘Euthanasia’ or ‘Assisted Suicide’. But we make it clear at the outset that Euthanasia and Assisted Suicide continue to be unlawful and we are dealing with a different matter ‘Withholding Life-support Measures’ to patients terminally ill and, universally, in all countries, such withdrawal is treated as ‘lawful’.

### The Seminar of April 2005

The Indian Society of Critical Care Medicine, Mumbai, approached the Law Commission of India requesting the participation of the Law Commission in a Seminar on “End-of-Life Issues” to be held on 27<sup>th</sup> April, 2005 at New Delhi in which the Union Minister for Law and Justice, Sri H.R. Bhardwaj was the Chief Guest. The Seminar was attended by Medical

Specialists, Legal Experts, and Media Personnel and issues relating to “withholding life support measures in dying patients” were discussed. It was obvious that several legal, moral, religious and ethical issues were involved in the above subject apart from social issues. The Seminar was organized in the wake of the Terri Schiavo Case (stopping life support) in USA and the case of Venkatesh (organ transplantation) in the Andhra Pradesh High Court. The Indian Society of Critical Care Medicine took the initiative to develop guidelines on these issues for ‘intensive care specialists’. The Society was of the view that there was need to develop appropriate legislation for end-of-life issues in our country.

Hon’ble Minister for Law and Justice Sri H.R. Bhardwaj agreed that there was need to develop some legal frame-work. The speakers included the Chairman of the Law Commission of India and Sri S. Balakrishnan, Senior Advocate, Supreme Court of India, Dr. Ram E. Rajagopalan, President of the Society, Dr. R.K. Mani, President (Elect) of the Society and Dr. Rajesh Chawla, Secretary of the Society.

A large number of senior doctors attended the seminar and emphasized the need for a law on the subject of ‘withholding of life-support’ to dying patients. Their main apprehension was that if the doctors took the risk of withdrawing life-support, there was the possibility of their being prosecuted for ‘abetting’ suicide under sec 306 of the Indian Penal, Code, 1860.

At that Seminar, the proposal that the Law Commission of India should come forward with a Paper on the subject of ‘withdrawal of life-

support' was accepted. But, the Commission realized soon that most of the cases before the doctors have given rise to purely legal issues. As the issues are legal issues, the Commission has decided to prepare a final Report.

Withdrawal of life support is different from Euthanasia or Assisted Suicide:

One of the first things that has to be taken note of is that 'withdrawal of life support' to patients is totally different from Euthanasia and Assisted Suicide.

The subject of withdrawal of life support to patients who are in a critical stage or under coma for long periods has attracted the attention of the law makers in various countries. There are statutes in some countries, and also guidelines issued by several Medical Councils and a large number of decisions of the Courts. There is a vast literature on the subject including Reports of several Law Commissions.

It is the position today in our country that attempt to commit suicide is an offence under sec 309 of the Indian Penal Code and abetment of suicide is also an offence as per sec 306. The word 'Abetment' is independently defined under sec 107 of the Penal Code.

‘Euthanasia’ is the act of killing someone painlessly, especially, for relieving suffering of a person from incurable illness. It is also called ‘mercy-killing’.

‘Assisted suicide’ is where a doctor assists a patient by giving him medicines at the request of a patient who is unable to withstand pain, for enabling the patient to bring his life to an end.

In our country, and in several countries (with very few exceptions), ‘Euthanasia’ and ‘Assisted Suicide’ are offences.

In this Report, we are of the view that ‘Euthanasia’ and ‘Assisted Suicide’ must continue to be offences under our law. The scope of the inquiry is, therefore, confined to examining the various legal concepts applicable to ‘withdrawal of life support measures’ and to suggest the manner and circumstances in which the medical profession could take decisions for withdrawal of life support if it was in the ‘best interests’ of the patient. Further, question arises as to in what circumstances a patient can refuse to take treatment and ask for withdrawal or withholding of life support measure, if it is an informed decision.

In that context, it will also become necessary to propose sufficient safeguards to the ‘patient’ so that the procedure proposed for doctors arriving at a decision for withdrawal of life support measures is not misused or abused by any body, including the patient, the relatives of the patient or the doctors or the hospitals where the patient is under treatment.

The Indian Society of Critical Care Medicine has already come forward with several guidelines for the use of the medical profession. It appears that the Medical Council of India has not so far framed any guidelines.

The Law Commission in its 42<sup>nd</sup> Report recommended the deletion of sec 309 of the Penal Code which makes the ‘attempt to commit suicide’ an offence. We make it clear that we are not concerned with that issue in this Report but we are concerned only with ‘withdrawal of life support’ to dying patients.

New method of presentation of legal principles adopted in this Report:

We felt that, in this Report, we have to deviate from the normal method of presentation of Report adopted in other Reports of the Law Commission. The legal principles applicable to stoppage of life-support systems cannot be understood unless one is able to know the facts in the leading cases where the principles of law have been laid down. Further, several of the law reports are not within the reach of the medical profession. In fact, some of the law reports to which we have referred are not available easily even to the members of the legal profession or the Judges. Hence, we decided to deal with each case in an extensive manner so that law makers, patients or their relatives, doctors, lawyers and Judges can understand in what circumstances, the particular principles of law were laid down. We felt that, a mere reference to a legal principle divorced from the facts, cannot furnish any idea about the applicability of the legal principles to any given

set of facts. We hope that this method adopted by us in this Report will be to the satisfaction of one and all.

In order to put our recommendations in legislative form, a draft of a Bill, namely, “Medical Treatment of Terminally Ill Patients (Protection of Patients, Medical Practitioners) Bill”, is annexed to this Report as ‘Annexure’.

## Chapter - II

### Supreme Court of India on suicide, euthanasia, assisted suicide, abetment of suicide, stopping life support treatment

The Supreme Court had occasion to discuss the issues of suicide, euthanasia, assisted suicide, abetment of suicide, stopping life sustaining treatment in Gian Kaur vs. State of Punjab: 1996(2) SCC 648.

As the Supreme Court referred to some of the provisions of the Indian Penal Code, 1860 in that connection, we shall refer to those provisions.

(a) Sections 107, 306 and 309 of the Indian Penal Code, 1860:

Section 306 of the Penal Code which refers to ‘abetment of suicide’, reads as follows:

“Section 306: If any person commits suicide whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall be liable to fine.”

Section 107 defines ‘abetment of a thing’ as follows:

“A person abets the doing of a thing, who  
First: Instigates any person to do that thing;

Secondly: Engages with one or more other person or persons in any conspiracy for the doing of that thing, if an act or illegal omission takes place in pursuance of that conspiracy, and in order to the doing of that thing; or

Thirdly: Intentionally aids, by any act or illegal omission, the doing of that thing.

Explanation 1: A person who by willful misrepresentation, or by willful concealment of a material fact which he is bound to disclose, voluntarily causes or procures, or attempts to cause or procure a thing to be done, is said to instigate the doing of that thing.

Explanation 2: Whoever, either prior to or at the time of the commission of an act, does anything in order to facilitate the commission of that act and thereby facilitates the commission thereof, is said to aid the doing of that act.”

Section 309 of the Code makes ‘attempt to commit suicide’ an offence and it states as follows:

“Section 309: Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine or with both.”

Thus, ‘attempt to commit suicide’ is an offence which may result in imprisonment (for a term which may extend to one year) or with fine or with both.

While dealing with sec 309, it is necessary to refer to two important decisions of the Supreme Court of India where, in the first case in P. Rathinam vs. Union of India 1994(3)SCC 394 a two-Judge Bench of the Supreme Court struck down sec 309 as unconstitutional and in the second case in Gian Kaur vs. State of Punjab: 1996(2)SCC 648 a Constitution Bench overruled the earlier judgment and upheld the validity of sec 309.

In both the judgments, the provisions of Art 21 of the Constitution of India which guarantees that no person shall be deprived of his life or personal liberty except according to procedure established by law, were interpreted. It was held in both cases, that, in any event, sec 309 did not contravene Art 14 of the Constitution of India.

We do not propose to discuss the first case of P. Rathinam which was overruled in the second case, Gian Kaur. But, it is necessary to state that in P. Rathinam, sec 309 ‘attempt to commit suicide’ was alone in question whereas in the second case, Gian Kaur, the question was about the validity of both sections 306 (abetment of suicide) as also sec 309 (attempt to commit suicide). In Gian Kaur, the appellants who were convicted under sec 306 for ‘abetment of suicide’ contended that if sec 309 dealing with ‘attempt to commit suicide’ was unconstitutional, for the same reasons, sec 306 which deals with ‘abetment of suicide’ must be treated as unconstitutional. But, the Supreme Court upheld the constitutional validity of both sec 306 and sec 309.

In Gian Kaur, the Supreme Court made it clear that ‘Euthanasia’ and ‘Assisted Suicide’ are not lawful in India and the provisions of the Penal

Code 1860 get attracted to these acts. But, the question is whether there is anything in Gian Kaur's case upholding sections 306 and 309, which either directly or indirectly deals with 'withdrawal of life support'?

(A) Fortunately, in the context of sec 306 (abetment of suicide), there are some useful remarks in Gian Kaur which touch upon the subject of withdrawal of life support. Before the Supreme Court, in the context of an argument dealing with 'abetment' of suicide, the decision of the House of Lords in Airedale N.H.S. Trust vs. Bland 1993(1) All ER 821, was cited. The Supreme Court referred to the distinction between withdrawing life support and euthanasia, as follows: (p. 665).

“Airedale N.H.S. Trust vs. Bland was a case relating to withdrawal of artificial measures for continuance of life by a physician. Even though it is not necessary to deal with physician assisted suicide or euthanasia case, a brief reference to the decision cited at the Bar may be made. In the context of existence in the persistent vegetative state of no benefit to the patient, the principle of sanctity of life, which is the concern of the State, was stated to be not an absolute one. In such cases also, the existing crucial distinction between cases in which a physician decides not to provide, or to continue to provide, for his patient, treatment of care which could or might prolong his life, and those in which he decides, for example, by administering a lethal drug, actively to bring his patient's life to an end, was indicated and it was then stated as under....” (emphasis suggested).

and their Lordships quoted the following passage from Airdale:

“But, it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering however great that suffering may be (See R vs. Cox (18.9.1992, unreported per Ognall J in the Crown Court at Winchester). So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and, on the other hand, euthanasia-actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at Common-law. It is of course well known that there are many responsible members of our society – who believe that euthanasia should be made lawful, but that result could, I believe, only be achieved by legislation which expresses the democratic will that so fundamental a change should be made in our law, and can, if enacted, ensure that such legalized killing can only be carried out subject to appropriate supervision and control”. (emphasis supplied)

The Supreme Court stated, after the above quotation from Airdale as follows: (p 665)

“The desirability of bringing about such a change was considered to be function of the legislature by enacting a suitable law providing therein adequate safeguards to prevent any possible abuse.”

In effect, the Supreme Court, while making the distinction between euthanasia, which can be legalized only by legislation, and ‘withdrawal of life-support’, appears to agree with the House of Lords that ‘withdrawal of

life support' is permissible in respect of a patient in a persistent vegetative state as it is no longer beneficial to the patient that 'artificial measures' be started or continued merely for 'continuance of life'. The Court also observed that the principle of 'sanctity of life, which is the concern of the State', was 'not an absolute one'.

(B) We may also refer to certain observations in Gian Kaur as to whether a 'right to die' with dignity was part of a 'right to live' with dignity in the context of Art 21 where death due to termination of natural life is certain and imminent and the process of natural death has commenced. The Court observed: (p 661)

“A question may arise, in the context of a dying man who is terminally ill or in a persistent vegetative state that he may be permitted to terminate it by a premature extinction of his life in those circumstances. This category of cases may fall within the ambit of the 'right to die' with dignity as a part of 'right to live' with dignity, when death due to termination of natural life is certain and imminent and the process of natural death has commenced.”

From the above passages, it is clear that the Supreme Court accepted the statement of law by the House of Lords in Airedale that 'euthanasia' is unlawful and can be permitted only by the legislature i.e. act of killing a patient painlessly for relieving his suffering from incurable illness. (and be subject to appropriate supervision and control). Otherwise, it is not legal. 'Assisted suicide' is where a doctor is requested by a patient suffering from

pain and he helps the patient by medicine to put an end to his life. This is also not permissible in law. Again, at p 661, the Supreme Court stated:

“These are not cases of extinguishing life but only of accelerating conclusion of the process of natural death which has already commenced. The debate even in such cases to permit physician-assisted termination of life is inconclusive. It is sufficient to reiterate that the argument to support the view of permitting termination of life in such cases to reduce the period of suffering during the process of certain-natural death is not available to interpret Art 21 to include therein the right to curtail the normal span of life.” (emphasis supplied).

The last sentence must be understood in the context of ‘assisted suicide’ and not in the context of withholding or withdrawing life support. But where a patient is terminally ill or is in a persistent vegetative state, a premature extinction of his life in those circumstances, by withholding or withdrawal of life support, is part of the right to live with dignity and, is permissible, when death due to natural termination of life is certain and imminent and the process of natural death has commenced.

The case of ‘withdrawal of artificial measures for continuance of life by a physician’, decided by Airedale N.H.S. Trust vs. Bland (1993 (1) All ER. 821 (HL)) deals with something different from euthanasia or physician assisted suicide. It relates to the withdrawal of artificial measures used by a physician for continuance of life. In the context of a patient in a persistent vegetative state with no benefit to himself, the principle of sanctity of life,

which is the concern of the State, has been stated to be not an absolute one. In such cases also, there is a crucial distinction between cases in which (a) a physician decides not to provide or continue to provide treatment or care which can or may prolong his life and (b) where the physician decides, for example, to administer a lethal drug, actively to bring an end to the patient's life. The former is permissible but the latter is not. Taking care of a living patient is different from crossing the Rubicon to resort to euthanasia. (para 40 of SCC)

If these are the guidelines that can be culled out from the judgment of the Supreme Court in Gian Kaur's case, which expressly referred to Airedale N.H.S. Trust vs. Bland, there is no difficulty in accepting the principles laid down in UK and other countries as to when it would be lawful for a patient or a doctor to direct stoppage of ventilation or artificial nutrition or other life sustaining treatment. We shall, therefore, deal elaborately with the principles of law laid down in UK and other countries. After referring to the case law in other countries, we shall come back to the provisions of the Indian Penal Code and to the tort law.

(b) Sections 87, 88 and 92 of the Indian Penal Code, 1860:

These sections of the Penal Code are also relevant and their relevancy can be seen in the various judgments that are analysed in the following chapters. For the present, we shall merely refer to these sections.

Section 87 of the Code is relevant. It deals with ‘Act likely to cause harm, but done without criminal intent and to prevent other harm’. It reads as follows:

“87. Act not intended and not known to be likely to cause death or grievous hurt, done by consent:

Nothing which is not intended to cause death, or grievous hurt, and which is not known by the doer to be likely to cause death or grievous hurt, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, to any person, above eighteen years of age, who has given consent, whether express or implied, to suffer that harm; or by reason of any harm which it may be known by the doer to be likely to cause any such person who has consented to take the risk of that harm.

Illustration: A and Z agree to fence with other for amusement. This agreement implies the consent of each to suffer any harm which in the course of such fencing, may be caused without foul play; and if A, while playing fairly, hurts Z, A commits no offence.”

Section 88 deals with ‘Act done in good faith for benefit of a person with consent’. It reads as follows:

“88. Act not intended to cause death, done by consent in good faith for person’s benefit:

Nothing, which is not intended to cause death, is an offence by reason of any harm which it may cause or be intended by the doer to cause or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied, to suffer that harm, or to take the risk of that harm.

Illustration: A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under a painful complaint, but not intending to cause Z's death, and intending, in good faith, Z's benefit, performs that operation on Z, with Z's consent. A has committed no offence."

Section 92 deals with 'Act done in good faith for benefit of a person without consent'. It reads as follows:

"92. Act done in good faith for benefit of a person without consent:

Nothing is an offence by reason of any harm which it may cause to a person for whose benefit it is done in good faith, even without that person's consent, if the circumstances are such that it is impossible for that person to signify consent, or if that person is incapable of giving consent, and has no guardian or other person in lawful charge of him from whom it is possible to obtain consent in time for the thing to be done with benefit:

Provided-

First – That this exception shall not extend to the intentional causing of death, or the attempting to cause death;

Secondly – that this exception shall not extend to the doing of anything which the person doing it knows to be likely to cause death, for any purpose other than the preventing of death or grievous hurt or the curing of any grievous disease or infirmity;

Thirdly – That this exception shall not extend to the voluntary causing of hurt, or to the attempting to cause hurt, for any purpose other than preventing of death or hurt;

Fourthly – That this exception shall not extend to the abetment of any offence, to the committing of which offence it would not extend.

Illustrations: (a) Z is thrown from his horse, and is insensible. A, a surgeon, finds that Z requires to be trepanned. A, not intending Z's death, but in good faith, for Z's benefit, performs the trepan before Z recovers his power of judging for himself. A has committed no offence.

(b) Z is carried off by a tiger. A fires at the tiger knowing it to be likely that the shot may kill Z, but not intending to kill Z, and in good faith intending Z's benefit. A's ball gives Z a mortal wound. A has committed no offence.

(c) A, a surgeon, sees a child suffer an accident which is likely to prove fatal unless an operation be immediately performed. There is no time to apply to the child's guardian. A performs the operation in spite of the entreaties of the child, intending, in good faith, the child's benefit. A has committed no offence.

(d) A is in a house which is on fire, with Z, a child. People below hold out a blanket. A drops the child from the housetop, knowing it to be likely that the fall may kill the child, but not intending to kill the

child, and intending, in good faith, the child's benefit. Here, even if the child is killed by the fall, A has committed no offence.

Explanation: Mere pecuniary benefit is not benefit within the meaning of sections 88, 89 and 92."

(C) Section 81 of the Code:

Section 81 of the Code is also relevant. It deals with 'Act likely to cause harm, but done without criminal intent and to prevent other harm. It reads as follows:

"81. Act likely to cause harm, but done without criminal intent, and to prevent other harm.

Nothing is an offence merely by reason of its being done with the knowledge that it is likely to cause harm, if it be done without any criminal intention to cause harm, and in good faith for the purpose of preventing or avoiding other harm to person or property.

Explanation: It is a question of fact in such a case whether the harm to be prevented or avoided was of such a nature and so imminent as to justify or excuse the risk of doing the act with the knowledge that it was likely to cause harm.

Illustrations: (a) A, the captain of a steam vessel, suddenly and without any fault or negligence on his part, finds himself in such a position that, before he can stop his vessel, he must inevitably run down a boat B, with twenty or thirty passengers on board, unless he changes the course of the vessel, and that, by changing his course, he must incur risk of running down a boat C with only two passengers

on board, which he may possibly clear. Here, if A alters his course without any intention to run down the boat C and in good faith for the purpose of avoiding the danger to the passengers in the boat B, he is not guilty of an offence, though he may run down the boat C by doing an act which he knew was likely to cause that effect, if it be found as a matter of fact that the danger which he intended to avoid was such as to excuse him in incurring the risk of running down the boat C.

(b) A, in a great fire, pulls down houses in order to prevent the conflagration from spreading. He does this with the intention in good faith of saving human life or property. Here, if it be found that the harm to be prevented was of such a nature and so imminent as to excuse A's act, A is not guilty of the offence."

We shall come back to these provisions, in the context of their applicability to 'stoppage of life support system', in Chapter VII, after discussing the comparative law in the other chapters.

### Chapter III

#### Principles of law laid down by the House of Lords in Airedale NHS Trust v. Bland:

We have already referred in Chapter II to the principles laid down by the House of Lords in Airedale case (1993)(1)All ER 821 (HL) which makes a distinction between withdrawal of life support on the one hand, and Euthanasia and Assisted suicide on the other. That distinction has been accepted by our Supreme Court in Gian Kaur's case 1996(2) SCC 648.

In this Chapter, we shall refer in detail to the facts in Airedale and to the views expressed by the Law Lords, and in particular by Lord Keith, Lord Goff of Chieveley and Lord Browne Wilkinson. We shall then refer to large number of cases decided in UK on the basis of the principles laid down in Airedale.

We shall start with the leading decision Airedale NHS Trust vs. Bland.

Airedale NHS Trust vs. Bland: 1993(1) All ER 821: (This was an appeal by the Official Solicitor, representing Mr. Bland).

Mr. Anthony Bland met with an accident and for three years, he was in a condition known as 'persistent vegetative state' (PVS). The said condition was the result of destruction of the cerebral cortex on account of prolonged deprivation of oxygen and the cortex had resolved into a watery

mass. The cortex is that part of the brain which is the seat of cognitive function and sensory capacity. The patient cannot see, hear or feel anything. He cannot communicate in any way. Consciousness has departed for ever. But the brain-stem, which controls the reflective functions of the body, in particular the heart beat, breathing and digestion, continues to operate.

In the eyes of the medical world and of the law, a person is not clinically dead so long as the brain-stem retains its function.

In order to maintain Mr. Bland in his present condition, feeding and hydration are achieved by artificial means of a nasogastric tube while the excretory functions are regulated by a catheter and other artificial means. The Catheter is used from time to time to give rise to infusions which have to be dealt with by appropriate medical treatment.

As for Bland, according to eminent medical opinion, there was no prospect whatsoever that he would ever make a recovery from his present condition but there was every likelihood that he would maintain the present state of existence for many years to come provided the artificial means of medical care is continued.

The doctors and the parents of Bland felt, after three years, that no useful purpose would be served by continuing the artificial medical care and that it would be appropriate to stop these measures aimed at prolonging his existence.

Since there were doubts whether withdrawal of life support measures could amount to a criminal offence, the Hospital Authority (the appellant) moved the High Court for a declaration designed to resolve these doubts. The Family Division of the High Court granted the declarations sought for on 19.11.92. That judgment was affirmed by the Court of Appeal (Sir Thomas Bingham M.R., Butler-Sloss and Hoffman L.JJ) on 9.12.1992. The declarations granted by the Court were as follows:

“that despite the inability of the defendant to consent thereto, the plaintiff and the responsible attending physicians:

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

On further appeal to the House of Lords, Lord Keith of Kinkel observed that the object of medical treatment and care is, after all, to benefit the patient. But it is unlawful, both under the law of torts and criminal law of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent (In re F. Mental Patient: Sterilisation) 1990 (2) AC 1. Such a person is completely at liberty to decline to undergo

treatment, even if the result of his doing will be that he will die. This extends to the situation where the person, in anticipation of his death through one cause or another and entering into a condition such as P.V.S., gives clear instructions that in such event, he is not to be given medical care, including artificial feeding, designed to keep him alive. The second point is that it very commonly occurs that a person due to accident or some other cause, becomes unconscious and is thus not able to give or withhold consent to medical treatment. In that situation, it is lawful, under the principle of necessity, for medical men to apply such treatment as in their informed opinion is in the “best interests” of the unconscious patient. In In re J (A Minor) (Wardship: Medical Treatment)(1991) Fam. 33, the Court of Appeal held it to be lawful to withhold life saving treatment from a very young child in circumstances where the child’s life, if saved, would be one irredeemably racked by pain and agony. In the case of a permanently insensate being, who if continuing to live would never experience the slightest actual discomfort, it is difficult, if not possible, to make any relevant comparison between continued existence and the absence of it. It is, however, perhaps permissible to say that to an individual with no cognitive capacity whatever, and no prospect of ever recovering any such capacity in this world, it would be a matter of complete indifference whether he lives or not. Lord Keith observed:

“a medical practitioner is under no duty to continue to treat such a patient where a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance. Existence in a vegetative state with no prospect of recovery is by that opinion regarded as not being a benefit, and that, if

not unarguably correct, at least forms a proper basis for the decision to discontinue treatment and care: (Bolam vs. Friern Hospital Management Committee 1957(1) WLR 582).

After stating that the principle of sanctity of life is important for the State, Lord Keith said it was not absolute. He said:

“It (the principle of sanctity of life) does not compel a medical practitioner on pain of terminal sanction to treat a patient, who will die, if he does not, contrary to the express wishes of the patient. It does not authorize forcible feeding of prisoners on hunger strike. It does not compel the temporary keeping alive of patients who are terminally ill where to do so would merely prolong their suffering. On the other hand, it forbids the taking of active measures to cut short the life of a terminally-ill patient. In my opinion, it does no violence to the principle to hold that it is lawful to cease to give medical treatment and care to a P.V.S. patient who has been in that state for over three years, considering that to do so involves invasive manipulations of the patient’s body to which he has not consented and which confers no benefit upon him.”

Lord Keith observed that the law in other countries, and in particular in USA was the same that such withdrawal is not treated as a criminal offence. He said:

“it is of some comfort to observe that in other common-law jurisdictions, particularly in the United States where there are many

cases on the subject, the Courts have, with near unanimity, concluded that it is not unlawful to discontinue medical treatment and care, including artificial feeding of P.V.S. patients and others in similar conditions”.

He also pointed out that, in order to protect the interests of patients, doctors and patients families and reassurance to the public, it is permissible to seek a declaration from the Family Division and the Court of Appeal for permission for withdrawal of life support. This is necessary till a body of experience and practice is built up.

Lord Goff of Chievely quoted from Lord Bingham’s judgment in the Court of Appeal and the following part of that extract from Lord Bingham’s Judgment is important:

“...in law, Anthony is still alive. It is true that his condition is such that it can be described as a living death; but he is nevertheless still alive. This is because, as a result of development in modern medicine and technology, doctors no longer associate death exclusively with breathing and heart beat, and it has come to be accepted that death occurs when the brain, and in particular the brain stem has been destroyed. (See Prof. Ian Kennedy’s paper entitled “Switching off life Support Medicines: The Legal Implications”, reprinted in Treat Me Right, Essays in Medical Law and Ethics (1988), especially at pp 351-352) ..... he is still alive...as a matter of law.

.... We are concerned with circumstances in which it may be lawful to withdraw from a patient medical treatment or care by means of which his life must be prolonged by such treatment or care, if available, regardless of the circumstances.

First, it is established that the principle of self determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests of the patient to do so (see Schloendorff vs. Society of New York Hospital (1914) 211 NY 125 per Cardozo J; S vs. McC (Orse S.) and M (D.S. Intervenor); W vs. W (1972) AC24(43) per Lord Reid; and Sidaway vs. Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital (1985) A.C 871(882) per Lord Scarman. To this extent, the principle of sanctity of human life must yield to the principle of self-determination (see ante, pp 351 H-352A, per Hoffman L.J) and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified. On this basis, it has been held that a patient of sound mind may, if properly informed, require that life support should be discontinued, See Nancy B vs. Hotel-Dieu de Quebec: (1992) 86 D.L.R. (4<sup>th</sup>) 385. Moreover, the same principle applies where the patient's refusal to give consent has been expressed at an earlier date, before he becomes unconscious or otherwise incapable of communicating it; though in such circumstances, especial care may

be necessary to ensure that the prior refusal of consent is still properly to be referred as applicable in the circumstances which have subsequently occurred: See, e.g. In re T (Adult: Refusal of Treatment) 1992(3) W.L.R. 782. I wish to add that, in cases of this kind, there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to do, declined to consent to treatment which might or would have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with his duty, complied with his patient's wishes." (emphasis supplied)

Lord Goff went on to further quote the following words of Lord Bingham on informed consent:

"But, in many cases, not only may the patient be in no condition to be able to say whether or not he consents to the relevant treatment or care, but also he may have given no prior indication of his wishes with regard to it. In the case of a child, who is a ward of Court, the Court itself will decide whether medical treatment should be provided in the child's best interests, taking into account medical opinion. But the Court cannot give its consent on behalf of an adult patient who is incapable of himself deciding whether or not to consent to treatment. I am of the opinion that there is nevertheless no absolute obligation upon the doctor who has the patient in his care to prolong his life, regardless of circumstances. Indeed, it would be most startling, and could lead to the most adverse and cruel effects upon a patient, if any such absolute rule were held to exist. It is scarcely consistent with

primacy given to the principle of self-determination in those cases in which the patient of sound mind has declined to give his consent, that the law should provide no means of enabling treatment to be withheld in appropriate circumstances where the patient is in no condition to indicate, if that was his wish, that he did not consent to it. The point was put forcibly in the judgment of the Supreme Court of Massachusetts in Superintendent of Belchertown State School vs. Saikewicz (1977) 370 N.E. 2d 417 (428) as follows:

“To presume that the incompetent person must always be subjected to what may rational and intelligent persons may achieve is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality.”

Lord Goff continued:

“I must, however, stress, at this point, that the law draws a distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life and those in which he decides, for example by administering a lethal drug, actively to bring the patient’s life to an end. As I have already indicated, the former may be lawful, either because the doctor is giving effect to his patient’s wishes by withholding the treatment or care, or even in circumstances in which (on principles which I shall describe), the patient is incapacitated from stating whether or not he gives his consent. But it is not lawful for a doctor to administer a drug to his patient to bring about his

death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be. See Reg vs. Cox (unreported) (18<sup>th</sup> Sept. 1992).... Euthanasia is not lawful at common law; but that result could, I believe, only be achieved by legislation....”

Lord Goff then quotes the crucial reasoning of Lord Bingham as to why stoppage of life support is not an offence. Bingham M. R. stated:

“Why is it that a doctor who gives his patient a lethal injection which kills him commits an unlawful act and indeed is guilty of murder, whereas a doctor who, by discontinuing life-support, allows his patient to die, may not act unlawfully – and will not do so, if he commits no breach of duty to his patient? Prof. Glanville Williams has suggested (See his Textbook of Criminal Law, 2<sup>nd</sup> Ed (1983) p 282) that the reason is that what the doctor does when he switches off a life support machine, “is in substance not an act but an omission to struggle”, and that “the omission is not a breach of duty by the doctor, because he is not obliged to continue in a hopeless case.”

Significantly, Lord Goff further explains what happens in a withdrawal of life support. He says:

“I agree that the doctor’s conduct in discontinuing life support can properly be categorized as an omission. It is true that it may be difficult to describe what the doctor actually does as an omission, for example, where he takes some positive step to bring the life support

to an end. But discontinuation of life support is, for present purposes, no different from not initiating life support, in the first place. In each case, the doctor is allowing his patient to die in the sense that he is desisting from taking a step which might, in certain circumstances, prevent his patient from dying as a result of his pre-existing condition; but as a matter of general principle, an omission such as this will not be unlawful unless it constitutes a breach of duty to the patient. I also agree that the doctor's conduct is to be differentiated from that of, for example, an interloper who maliciously switches off a life support machine... Accordingly, whereas the doctor in discontinuing life support, is simply allowing his patient to die of his pre-existing condition, the interloper is actively intervening to stop the doctor from prolonging the patient's life, and such conduct cannot possibly be categorised as an omission.

.....discontinuance of life support can be differentiated from ending a patient's life by a lethal injection. .... the reason for that difference is that, whereas the law considers that discontinuance of life-support may be consistent with the doctor's duty to care for his patient, it does not, for reasons of policy, consider that it forms part of his duty to give his patient a lethal injection to put him out of his agony.”

After referring to In re F (Mental Patient: Sterilisation) 1990(2) AC 1, in which it was held that a doctor may, when treating an unconscious patient, treat such a patient if he acts in his “best interests” – Lord Goff said, the same principle applies when a doctor decides whether or not to stop the life

support in the best interests of the patient. A doctor, for example, is not, as held by Thomas J in Auckland Area Health Authority vs. AG:1993(1) NZLR 235 bound to perform a surgery on a cancer patient if it is likely to result in shortening the patient's life further. He may then lawfully administer palliatives to reduce the pain and suffering. He said that, therefore,

“when the doctor's treatment of his patient is lawful, the patient's death will be regarded in law as exclusively caused by the injury or disease to which his condition is attributed.”

Life support systems are new innovations in Medical technology. Life support methods can be initially adopted, “But if he neither recovers sufficiently to be taken off it nor dies, the question will ultimately arise whether he should be kept on it indefinitely.” After quoting Prof. Ian Kennedy and from Thomas J of New Zealand, Lord Goff said that the question is not whether the doctor should take a course which will kill the patient, the question is “whether in the best interests of the patient that his life should be prolonged by the continuance of this form of medical treatment or care. In the present case the continuance is, according to doctor, of no utility at all as it has no therapeutic purpose of any kind”.

Rejecting the American Court's view that a surrogate or substitute could be allowed to take a decision on behalf of an incompetent patient, (see In re Quinian : (1976) 355 A. 2d. 647 and Superintendent of Belchertown State School vs. Saikewicz 370 N.E. 2d 417, Lord Goff said:

“.... I do not consider that any such test forms part of English law in relation to incompetent adults, on whose behalf nobody has power to give consent to medical treatment. Certainly, in In re F 1990(2) AC 1, your Lordship’s House adopted a straightforward test based on the best interests of the patient;....”

Lord Goff finally approved Lord Bingham MR’s view that Courts could grant declarations for stoppage of life support, in the interests of patients, doctors and patients’ families and in the context of re-assurance to the public.

Lord Lowry agreed with Lord Goff.

Lord Browne-Wilkinson’s opinion is equally important. We shall only refer to certain important aspects.

Lord Browne-Wilkinson stated that till recently, death was beyond human control but recent developments in medical science have fundamentally affected those previous uncertainties. “In medicine, the cessation of breathing of heartbeat is no longer death. By the use of a ventilator, lungs which in the unaided course of nature would have stopped breathing, can be made to breathe, thereby sustaining heartbeat..... This has led medical profession to redefine death in terms of brain-stem death.” In medical terms, an unconscious patient kept alive by use of a ventilator is called ‘a ventilated corpse’. He also poses the question, arising out of modern technology:

“Given that there are limited resources available for medical care, is it right to devote money to sustaining the lives of those who are, and always will be, unaware of their own existence rather than to treating those who, in a real sense, can be benefited e.g. those deprived of dialysis for want of resources.”

New problems have also arisen in computing damages in accident cases on the basis whether the person is alive or dead. Question of succession depends upon the timing of death.

Omission to do certain thing may constitute offence “where the accused was under a duty to the deceased to do the act which he omitted to do”. Counsel Mr. Munby contended that ‘removal of the nasogastric tube necessary to provide artificial feeding and the discontinuance of the existing regime of artificial feeding’, constitute ‘positive acts of commission’. Lord Browne Wilkinson said: (p 881)

“I do not accept this. Apart from the act of removing the nasogastric tube, the mere failure to continue to do what you have previously done, is not, in any ordinary sense, to do anything positive; on the contrary, it is by definition an omission to do what you have previously done.

The positive act of removing the nasogastric tube presents more difficulty. It is undoubtedly a positive act, similar to switching off a ventilator in the case of a patient whose life is being sustained by artificial ventilation. But, in my judgment, in neither case should the act be classified as positive, since to do so would be to introduce

intolerably fine distinctions. If, instead of removing the nasogastric tube, it was left in place but no further nutrients were provided for the tube to convey to the patient's stomach, that would not be an act of commission. Again, as has been pointed out (Skegg, 'Law, Ethics and Medicine' (1984) p. 169 et seq), if the switching off a ventilator were to be classified as a positive act, exactly the same result can be achieved by installing a time-clock which requires to be re-set every 12 hours; the failure to reset the machine could not be classified as a positive act."

His lordship concluded:

"In my judgment, essentially what is being done is to omit to feed or to ventilate; the removal of the nasogastric tube or the switching off of a ventilator are merely incidents of that omission. (See Glanville Williams, Textbook of Criminal Law, p. 282; Skegg, p. 169 et seq)".

Any treatment given by a doctor to a patient which is invasive (i.e. involves any interference with the physical integrity of the patient) is unlawful unless done with the consent of the patient; it constitutes the crime of battery and the tort of trespass to the person. In the case of a charge of murder by omission to do an act and the act of omission could only be done with the consent of patient, refusal by the patient, will be a valid defence for a doctor.

“The doctor cannot owe to the patient any duty to maintain his life where that life can only be sustained by intrusive medical care to which the patient will not consent.”

In the case of minors, the Court, exercising the Crown’s right as parens patriae under the wardship jurisdiction, can consent on the child’s behalf. Until 1960 (in UK), the Court had the same parens patriae jurisdiction over adults who were mentally incompetent. But by the joint effect of the Mental Health Act, 1959 and the revocation of the warrant under the Sign Manual under which the jurisdiction of the Crown as parens patriae over those of unsound mind was conferred on the Courts, the Courts ceased to have any parens patriae jurisdiction over the person of a mentally incompetent adult, being left only with the statutory jurisdiction over his property (as opposed to his person) conferred by the Act of 1954.

Lord Browne Wilkinson observed:

“Faced with this problem, the House of Lords in In re F. (1990) (2) A.C. page 1, developed and laid down a principle, based on concepts of necessity, under which a doctor can lawfully treat a patient who cannot consent to such treatment if it is in the interests of the patient to receive such treatment. In my view, the correct answer to the present case depends on the extent of the right to continue lawfully to invade the bodily integrity of Anthony Bland without his consent. If, in the circumstances, they have no right to continue artificial feeding, they cannot be in breach of any duty, by ceasing to provide such feeding.”

While accepting the procedure of obtaining a declaration from Court, he says:

“(In re F), both Lord Brandon of Oakbrook (at p.64) and Lord Goff (at p.75, 77) make it clear that the right to administer invasive medical care is wholly dependent upon such care being in the best interests of the patient. Moreover, a doctor’s decision whether invasive care is in the best interests of the patient falls to be assessed by reference to the test laid down in Bolam v. Frienn Hospital Management Committee 1957 (1) WLR 582, viz., is the decision in accordance with a practice accepted at the time by a responsible body of medical opinion.”

On the basis of that test, Lord Browne-Wilkinson concludes that “if there comes a stage where the responsible doctor comes to the reasonable conclusion (which accords with the views of a responsible body of medical opinion), that further continuance of an intrusive life support system is not in the “best interests” of the patient, he can no longer lawfully continue that life support system; to do so would constitute the crime of battery and the tort of trespass to the person. Therefore, he cannot be in breach of any duty to maintain the patient’s life. Therefore, he is not guilty of murder by omission.”

The above judgment of the House of Lords in Airedale lays down a crucial principle of law when it says that withholding or withdrawal of life support to a dying patient merely amounts to allowing the patient to die a

natural death and that where death in the normal course is certain, withholding or withdrawal of life support is not an offence.

If a patient capable of giving informed consent refuses to give consent or has, in advance, refused such consent, the doctor cannot administer life support systems to continue his life even if the doctor thinks that it is in the patient's interest to administer such system. The patient's right of self-determination is absolute. But the duty of a doctor to save life of a patient is not absolute. He can desist from prolonging life by artificial means if it is in the best interests of the patient. Such an omission is not an offence. The doctor or the hospital may seek a declaration from the Court that such withholding, which is proposed, will be lawful.

In this Chapter, we have set out the broad principles laid down by the House of Lords in Airedale. In the next Chapter, we shall refer to other cases decided in UK before and after Airedale.

## Chapter IV

### Other cases decided in UK and Ireland before and after Airedale

Airedale (1993) decided by the House of Lords, has been followed in a number of cases in UK and it was pointed out that in the case of incompetent patients, if doctors act on the basis of informed medical opinion, and withdraw the artificial life-support systems if it is in the patient's best interests, then the said action cannot be characterized as an offence under criminal law. Even before Airedale, there are important judgments which got crystallized in Airedale.

The question arises as to what is meant by the words 'best interests of the patient'. This question is interlinked with another important aspect dealing with the consent or wishes of the patient or in case the patient is a minor, on the wishes of the parents, or where the patient is in permanent vegetative state, as to who should decide about this. As everybody, including the doctors and the Court have to give weight to the wishes of the patient or his parents, question arises whether the thinking of the patient or the parents is based upon a rational analysis of the problem or is based on irrelevant matters. Therefore, it has been held that the consent or refusal of the patient or parents is entitled to weight, only where it is an informed one, in the sense that the decision has been taken after full knowledge of the choices or otherwise of life support systems prolonging the life without pain or suffering.

In as much as, from the point of view of the State, life is sacrosanct and every effort should be made to continue life in a patient, the question arises when a patient's parents' desire to stop life-support system, can be accepted? In case there is divergence of opinion between the opinions of the patient/parents on the one hand and that of the doctors on the other, whether it will always be necessary for any of these or all of them to obtain the opinion of the Court of Law? These aspects have come up for decision in UK in several cases.

We shall now refer to other decisions of UK on this subject to show the gradual development of the law in UK on these important issues.

(1) Re B (a minor)(wardship: medical treatment): 1981(1)WLR 1421 (Templeman & Dunn LJ): A baby girl was suffering from a Down's Syndrome since her birth and she also had intestinal blockade which was amenable to surgery. If surgery was not done, she would die in a few days. With surgery, she could live upto 20 to 30 years. The parents objected to permission for surgery as they felt that the child would remain mentally and physically handicapped, if she survived. The local authority made her a ward of Court and applied to the Court to direct the surgery to be carried on. Ewbank J held that the parents' view should be respected and that it was not in the best interests of the child to authorize the surgery.

But the Court of Appeal differed on the ground that, if operated, the child would live the normal life span of a 'mongoloid child' with the handicaps/defects/life of such a child and in as much as it was not established that a life of that description ought to be extinguished.

The Court of Appeal held that as the child had been made a ward of the Court, the Court would decide what was in the “best interests” of the child and the decision did not lie with the parents or doctors, though the views of the parents and doctors will be kept in mind. The Trial Court erred in going only by the wishes of the parents. The Court directed the surgery to be conducted.

2. Re J (a minor) (Wardship: medical treatment): 1990(3) All ER 930. (Lord Donaldson of Lynton MR, Balcombe & Taylor L JJ)

This was again a case of a ward of Court. One J, born prematurely, who suffered from severe brain damage and the brain tissue was irreplaceable. He was epileptic and the medical evidence was that he was likely to develop spastic quadriplegia, would be blind and deaf and was unlikely even to be able to speak or develop intellectual faculties. His life expectancy was uncertain but he was expected to die before late adolescence, although he could survive a few years.

He had been ventilated twice for long periods and treatment was both painful and hazardous. Further re-ventilation, doctors felt, would result in his collapse. Question before the Court was whether if breathing should stop, re-ventilation should be done or not?

The trial Judge, in parens patriae jurisdiction, directed treatment but held that he be not re-ventilated. The Official Solicitor appealed against withholding life saving treatment.

The appeal be dismissed in as much as the child suffered from physical disabilities so grave that his life would, from his point of view, be so “intolerable” if he were to continue living, that he would have chosen to die if he were in a position to make a sound judgment and in such situations, the Court could direct that “treatment without which death would ensue from natural causes, need not be given to the ward to prolong his life, even though he was neither on the point of death nor dying.” However, the Court could never permit termination of life by the taking of positive steps. In deciding whether to authorize that treatment need not be given, “the Court had to perform a balancing exercise in assessing 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 judgment, to survive, and taking into account “the pain and suffering and quality of life” which he would experience if life was prolonged and the pain and suffering involved in the proposed treatment. Having regard to the invasive and hazardous nature of the re-ventilation, the risk of further deterioration if J was subjected to it and the extremely unfavourable progress with or without the treatment, it was in J’s best interests that authority for re-ventilation be withheld.

Donaldson MR stated that the child who was a ward or could be treated medically in exactly the same way as one who is not medically fit, the only difference being that the doctors will be looking to the Court rather than to the parents for necessary consent. In allocating limited resources to particular patients, the fact that a child is or is not a ward of Court, is irrelevant. Balcombe LJ stated that the Court while exercising parens

patriae jurisdiction of the sovereign, was not expected to adopt any higher or different standard than that which, viewed objectively, a reasonable and responsible parent would have taken.

Taylor LJ observed that in deciding against providing treatment, the Court must be satisfied to a high degree of probability that its decision is in the child's best interests; certainty of proof was not required.

Lord Donaldson observed that in most cases, this (stopping treatment) would be a matter to be discussed and decided by doctors in consultation with parents. That did not mean that parents could tell the doctors what to do, but they would have the right to withhold consent to treatment, subject to the right of the doctors to apply to the Court to make the child a ward of Court and to seek guidance from Court. (In the present case, there was difference of opinion between doctors and parents as to whether that treatment should be withheld).

He also held that in principle, neither the Court nor the parents could insist upon doctors that a particular treatment which the doctor found to be not suitable, should be given to the patient. The inevitable and desired result is that choice of treatment is in some measure a joint decision of the doctor, and the Court or parents.

He also said that, 'in an imperfect world, resources will always be limited and on occasion, agonizing choices will have to be made in allocating those resources to particular patient. He referred to Re C (a minor) (wardship: medical treatment) 1989(2) All ER 702 where a child was

dying and no amount of medical skill or care could do more than a brief postponement of the moment of death.

Lord Donaldson referred to the decision of the Supreme Court of British Columbia in Re Superintendent of Family and Child Science and Dawson (1983) 145 DLR (3d) 610). In that case the child was severely brain damaged and the question was whether the child could be subjected to a 'simple' kind of surgical treatment which would ensure the continuation of his life or whether, when the parents did not consider it to be in the child's best interests as it would be a life of suffering, such surgery should not be done so that the child could die with dignity. He quoted the judgment of McKenzie J of the Supreme Court of British Columbia to the following effect:

"I do not think that it lies within the prerogatives of any parent or of this Court to look down upon a disadvantaged person and judge the quality of that person's life to be so low as not to be deserving of continuance. The matter was put in an American decision – Re Weberlist (1974) 360 NYS (2d) 783 (at 787) where the learned Asch J said:

"There is a strident cry in America to terminate the lives of other people – deemed physically or mentally defective.... Assuredly, one test of a civilization is its concern with the survival of the 'unfittest', a reversal of Darwin's formulation.... In this case, the Court must decide what its ward would choose, if he were in a position to make sound judgment."

This last sentence puts it right. It is not appropriate for an external decision-maker to apply his standards of what constitutes a liveable life and exercise the right to impose death if that standard is not met in his estimation. The decision can only be made in the context of the disabled person viewing the worthwhileness or otherwise of his life in its own context as a disabled person – and in that context, he would not compare his life with that of a person enjoying normal advantages. He would know nothing of a normal person’s life, having never experienced it.”

Lord Donaldson clarified that what was in issue was not a right to impose death but a right to choose a course of action which would fail to avert death. The choice was that of the patient, if of full age and capacity, the choice was that of the parents or Court if, by reason of his age, the child would not be able to make the choice and it was a choice which must be made solely on behalf of the child and in what the Court or parents conscientiously believe to be “in his best interests”. He held that the Canadian Judgment should not be understood as advocating an absolutist approach. “In real life, there are presumptions, strong presumptions and almost overwhelming presumptions, but there are few, if any, absolutes”.

He distinguished Re B (1981)(1) WLR 142) as a case where having regard to the suffering of the child from his birth with Downs’s Syndrome and was a mongol, the parents, with great sorrow, came to the conclusion that it was not in the best interests of the child to continue his life. The parents did not view it from the point of view of the child, if capable of taking a decision. Hence, the burden shifted to the Court. Further in that

case, there were differences in the opinions of the surgeons. The Court gave its consent for surgery as it considered it was not a case ‘demonstrably so awful’ or ‘intolerable’. Lord Donaldson continued:

“We know that the instinct and desire for survival is very strong. We all believe in and assert the sanctity of human life. As explained, this formulation takes account of this and also underlines the need to avoid looking at the problem from the point of view of the decider but instead, requires him to look at it from the point of view of the patient. This gives effect, as it should, to the fact that even very severely handicapped people find a quality of life rewarding which to the unhandicapped may seem manifestly intolerable. People have an amazing adaptability. But in the end, there will be cases in which the answer must be that it is not in the interests of the child to subject it to treatment which will cause increased suffering and produce no consummate benefit, giving the fullest possible weight to the child’s and mankind’s desire to survive”.

Here, as regards J, the doctors were unanimous that any invasive procedure, such as introduction of a naso-gastric tube drips which have to be given and that constant blood sampling, would cause the child distress. Hence, discontinuance of life-support was held valid.

- (3) Re C (a minor) (wardship: medical treatment): 1989(2) All ER 782 (19/20 April, 1989) (CA).  
(Lord Donaldson of Lynton MR, Balcombe, Nicholls JJ).

In this case a baby was made a ward of Court shortly after her birth by the local authority as it was felt that her parents would have great difficulty in looking after her. The child was seriously brain damaged, severely handicapped and terminally ill. The medical opinion was that only palliative care could be given to relieve pain and suffering rather than to achieve prolongation of life. The trial Court, which was approached by the local authority, heard the Official Solicitor as the child's guardian-ad-litem, and granted leave "to treat the ward in such a way that she ended her life peacefully with least pain, suffering and distress and that the hospital was not required to treat any serious infection which the baby contracted nor need it set up any intravenous feeding system for her." The official Solicitor appealed.

The Court of Appeal affirmed it and held that where the ward of Court was terminally ill, the Court would authorize treatment which would relieve the ward's suffering during the remainder of his or her life and would accept the opinion of the doctors that the aim was only to relieve suffering rather than achieve a short prolongation of life. The Court could not, however, give directives as to how the child could be treated, hence the directions of the trial Judge not to treat for serious infections or intravenous feeding were set aside.

Lord Donaldson referred to B (a minor) (Wardship : medical treatment) Re: (1981)(1) WLR 1421 (CA); B (a minor) (Wardship : sterilization) Re: 1987 (2) All ER (HL) = 1988 A.C. 199; Re D (a minor) (Wardship: Sterilisation) Re 1976(1) All ER 326.

In Re D (1976) above mentioned, Heilborn J had stated that “once a child was a ward of Court, no important step in the life of that child, can be taken without the consent of the Court.”

Lord Donaldson referred to Re B (1981) (1) WLR 1421 (CA) above and to the view expressed therein that the ‘best interests’ of the child are alone relevant rather than just going by the parents’ views. He said that in Re B (1987) (HC), it was also said that the paramount consideration was the well-being, welfare and interests of the ward.

We next come to the separate Judgment of Balcombe LJ. He distinguished the judgment of the Canadian Court in Re SD 1983(3) WWR 618 decided by McKenzie J. In that case a seven year old boy had severe brain damage caused by meningitis. The question was whether an operation to revise a ‘shunt’ (a plastic tube which drains excess cerebrospinal fluid away from the brain) which had become blocked, should be performed. The boy’s parents opposed on the ground that he should be allowed to die with dignity rather than to continue to endure a life of suffering. The evidence there was that, without a shunt revision, the boy would not necessarily die but might live for months or years. McKenzie J said (629) that was

“not a ‘right to die’ situation where the Courts are concerned with people who are terminally ill from incurable conditions. Rather, it is a question whether S, has the right to receive appropriate medical and surgical care of a relatively simple kind which will assure him the continuation of his life, such as it is.”

Balcombe LJ made another significant remark:

“Courts in the United States of America have also been faced with similar cases and the problem has been the subject of discussion at legal conferences. Nevertheless, neither in this country nor, so far as I know, elsewhere has the legislature attempted to lay down the guidelines for the Courts or others faced with a problem of the type that arises in this case”.

In this case, there is also significant remark which came from Lord Donaldson was that in these type of cases, the name of the patient as well as opinions of professors etc., should be kept confidential and not referred to in the judgment of the Court. He stated:

“What is required in such cases is that the Judge should give judgment in open Court, taking all appropriate measures to preserve the personal privacy of those concerned.... Thus, in this judgment, I have quoted extensively from the Professor’s advice without, I hope, giving any clue as to his identity or that of C, her parents or the authority involved.”

- (4) Re C (a minor)(Wardship : medical treatment) No.2 (A) 1989(2) All ER 791  
 (Lord Donaldson of Lynton MR, Balcombe and Nicholas L JJ)  
 (21/26 April 1989)

This judgment refers to need to restrict ‘freedom of publication’ and to the harm which publications may cause to the ward. Question was whether injunction could be granted against newspapers wishing to identify and interview those involved in the care and treatment of the ward, and from publishing details of care and treatment and family background.

The Court heard the application of Daily Mail and Mail on Sunday made before the Court of Appeal to review its earlier order of 20.4.1989 restraining any person from making or causing or permitting inquiry directed to ascertain the identity of the patients, patient’s parents, doctors, hospital and medical advice.

The review was allowed in part. It was held that since publicity about the medical treatment of the ward of the Court could affect the quality of care given to her, the public interest – that is required in ensuring that the quality of care she was receiving did not suffer - would require the Court, in the interests of the ward, to issue an injunction prohibiting identification of the ward, the parents or publication of information in that regard, notwithstanding that the ward may be incapable of noticing such identification or publicity. Moreover, such an injunction would reinforce the duty of confidentiality owed by those caring for her. The injunction against identifying the parents was justified in order to protect the wardship jurisdiction since parents might refuse to make a child a ward of Court if they thought that they might be identified and singled out for media attention.

(Of course, while external publication should be stopped, the doctors and hospital or local authority must know the real name of the patient or names of parents so that it can have an idea as to the patient in respect of whom the Court has passed orders – in regard to continuing or withdrawing life support etc.)

- (5) Ward of Court, Re a: (1995) ILRM 401) (Hamilton CJ, O’Flaherty, Egan, Blayney, Denham JJ) (Ireland) (Supreme Court) (Appeal against the order of Lynch J of the High Court.)

The ward born in 1950, suffered irreversible brain damage as a result of anesthesia during 1972 and for several decades, the ward was invalid, the mother of the child was appointed in 1994 by the Court to be guardian of the person and estate of the child and in 1995 she sought directions from the Court for withdrawal of all artificial nutrition and hydration and to give necessary directives as to the child’s care.

In this case, the child suffered brain damage of a serious nature, she was spastic, both arms and hands were contracted, both legs and feet were extended, her jaws were clenched, for otherwise she would bite inside of her cheeks and tongue, her back-teeth had been capped to prevent the front teeth from fully enclosing. She could not swallow, she could not speak. She was incontinent. For 20 years she was fed through nasogastric tube. It was painful, and was replaced by gastrostomy tube in 1972 which required administration of general anaesthetic. The tube became detached in Dec 1993, and a new tube was inserted under general anaesthesia. The ward’s heart and lungs were functioning normally. She could not speak. She had a

minimal capacity to recognize – those who were attending on her over a long period. She tracked people with her eyes and reacted to noises, although it was mainly a reflex from the brain stem.

The High Court which heard the case gave consent for such withdrawal of nourishment by tube, whether nasogastric or the gastrostomy tube and decided such termination lawful. It consented to the non-treatment of infections or other pathological conditions which may effect the ward (except palliative care to avoid pain and suffering) and declared such treatment lawful; it authorized the mother and family to make such arrangements as they considered suitable and appropriate for the admission of the ward to a type of institution which was not contrary to their philosophy and ethics and to proceed in accordance with the consensus and declarations made (It stayed the order for 21 days to enable parties to move the Supreme Court).

In the Supreme Court, the judgment was confirmed. Hamilton CJ considered various important aspects of law which were troubling the Irish Courts in several cases.

It referred to Balcombe LJ's observations in In re J (a minor) (wardship: Medical Treatment) 1990(3) All ER 930 (p. 441), that in deciding what is in the best interests of a ward, the Court adopts the same attitude as a responsible parent would do in the case of his or her own child; the Court, exercising the duties of the sovereign as parens patriae, is not expected to adopt any higher or different standard than that which, viewed objectively, a reasonable and responsible parent would do.

The appellate Court was convinced that the ward was not fully in Permanent Vegetative State (PVS), as she has minimal cognitive capacity. However, after 20 years, there was no prospect of her improvement.

The mother and family members supported discontinuance of life-support.

After quoting extensively from Airedale decided by the House of Lords, and to the findings of the High Court, Hamilton CJ quoted Sir Thomas Bingham M.R. in Airedale that euthanasia and assisted suicide were different, as follows:

“It is, however, important to be clear from the outset what the case is, and is not, about. It is not about euthanasia, if by that it meant the taking of a positive action to cause death. It is not about putting down the old and infirm, the mentally defective or the physically imperfect.... The issue is whether artificial feeding and antibiotic drugs may lawfully be withheld from an insensate patient with no hope of recovery when it is known that if that is done, the patient will shortly, thereafter die.”

He then considered the provisions of the Irish Constitution in Chapter XII thereof. Art 40 enumerates “personal rights”, (including the right to life etc.). Art 41 enumerates the rights of the ‘Family’ and deals with the effect of grant of permission to withdraw life-support system in relation to these rights. He stated that the nature of the ‘right to life’ and its importance

imposed a strong presumption in favour of taking all steps capable of preserving it, save in exceptional circumstances. The problem was to define such circumstances. He stated:

“As the process of dying is part, and an ultimate, inevitable consequence of life, the right to life necessarily implies the right to have nature taken its course and to die a natural death and, unless the individual wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means, which have no curative effect and which is intended merely to prolong life.

The right, as so defined, does not include the right to have life terminated or death accelerated, and is confined to the natural process of dying. No person has the right to terminate or to have terminated his or her life, or to accelerate or have accelerated his or her death.”

In as much as here the patient is maintained artificially and the treatment is in no way, nor intended to be, curative and has been so for twenty years, there is no termination of life involved.

Hamilton CJ also stated that the right to bodily integrity, privacy and self-determination are “unenumerated rights” but are implied by the ‘right to life’. They are available if the patient is mentally competent and he or she could wish the artificial treatment to be discontinued even if it would result in death. The artificial treatment being intensive, constitutes an interference with the integrity of her body and cannot be regarded as normal means of nourishment. ‘A competent adult, if terminally ill, has the right to forego or

discontinue life-saving treatment. Treatment being afforded to a ward constitutes ‘medical treatment’ and not merely ‘medical care’, as stated by Sir Stephen Brown in Airedale N.H.S. Trust. Artificial feeding by means of a nasogastric tube is ‘medical treatment’. As the ward is unable to exercise the right for stopping medical treatment, it was not open to any person or persons to exercise that right on her behalf. All citizens shall, as human persons, be equal before the law. The loss by an individual of his or her mental capability does not result in diminution of her life or her personal rights recognized by the Constitution, including the right to life, the right to bodily integrity, the right to privacy, including self-determination and the right to refuse medical care or treatment. The ward is unable to have all these rights respected, defended, vindicated and protected from unjust attack, in spite of the lessened or diminished capacity. By reason of the fact that she is a ward of Court and the provisions of sec 9 of the Courts (Supplemented Provisions) Act, 1961 apply, the responsibility for the exercise and vindication of these rights rests on the Court. The first consideration is the paramount well-being, welfare and interests of the ward as stated by Lord Hailsham L.C. in Re (A Minor: Wardship: Sterilisation) (1988 AC 199 at p 202). As stated by Balcombe J in In Re J (A Minor Wardship: Medical Treatment): 1990(3) All ER 930, the Court as representative of the Sovereign as parens patriae will adopt the same standard which a reasonable and responsible parent would do. The Court has regard to the constitutional rights of the ward and is bound to defend and vindicate these rights.

On this basis, the Supreme Court was satisfied to take the ‘awesome’ decision to consent to the withdrawal and termination of the abnormal

artificial means of nourishment by tube, thus ceasing to prolong her life to no useful purpose and allowing her to die. “The true cause of the ward’s death will not be the withdrawal of such nourishment but the injuries which she sustained on the 26<sup>th</sup> April, 1972”. The trial Judge, while permitting discontinuance, had regard to the fact that the “treatment was intrusive and burdensome and of no curative effect, to the fact that the ward had only minimal cognitive function, had been in that condition for twenty three years, to the wishes of the mother and other members of the family, to the medical evidence and to the submissions by all the parties to the proceedings.”

In a separate concurring Judgment, O’Flaherty J referred to Walsh vs. Family Planning Services Ltd (1992) I.R. 496 to say that a competent person must give consent to medical treatment and, as a corollary, has an absolute right to refuse medical treatment even if it leads to death. In American law, this right is the constitutional right to self-determination (otherwise right to bodily integrity) as well as being regarded as a privacy right. So it is in Irish Law (Ryan vs. AG: (1965) I. R 94 and Kennedy vs. Ireland: (1987) I.R. 587. If the ward is unable to make a decision for withdrawal of treatment, consent has to be given on her behalf. In regard to “right to life”, Art 2 and 6 of the European Convention and Art 6 of the ICCPR are relevant. He said:

“This case is not about terminating a life but only to allow nature to take its course which would have happened even a short number of years ago and still does in places where medical technology has not advanced so much as in this country.”

He quotes a beautiful passage from the Supreme Court of Arizona in Rasmussen vs. Fleming (1987) 154 Ariz 207 as follows:

“Not long ago, the realms of life and death were delineated by a bright line. Now this line is blurred by wondrous advances in medical technology – advances that until recent years were only ideas conceivable by such science fiction visionaries as Jules Verne and H.G. Wells. Medical technology has entered a twilight zone of suspended animation where death commences while life, in some form, continues. Some patients, however, want no part of a life sustained only by medical technology. Instead, they prefer a plan of medical treatment that allows nature to take its course and permits them to die in dignity.” (emphasis supplied)

He refers to the judgment of the State Appellate Court in US in In re Fiori (1995) A.R.(2d) 1350 where more than 50 decisions of US Courts were reviewed and states: “It appears near judicial unanimity has been attained in the United States to permit a course similar to that sanctioned by the learned trial Judge in this case”. The following summary of US cases was given:

“(1) Absent the existence of a statute on the subject, the various legal precepts relied upon to authorize the withdrawal of sustenance from a person in a persistent vegetative state have been reduced to a ‘best interest’ analysis, ‘substituted judgment criterion’ and a ‘clear and convincing’ evidence standard of proof which draw their strengths from the federal and state constitutional rights of privacy.

(2) Equally applicable to the right of an individual to forego life sustaining medical treatment is the common law right to freedom from unwanted interference with bodily integrity (self-determination).

(3) But the right to bodily integrity can be exercised only by a person competent to evaluate her condition. Otherwise, it has to be exercised by a surrogate under the doctrine of ‘substituted judgment’. Courts will rely on ‘substituted judgment’ doctrine only when the surrogate decision maker demonstrates the incompetent person’s preferences with reasonable certainty. When the patient expresses a treatment-preference prior to her loss of competence, the Court views the surrogate as merely supplying the capacity to enforce the incompetent’s choice. Thus, a dying patient’s right to self-determination out-weighs the rights of the patient’s family, physician or other care provider to base a treatment determination on that individual interests or ethical imperatives. The irreversible incompetent’s right to self-determination also outweighs the States interest in preserving life, preventing suicide, protecting third party dependants of the dying patient, and preserving the ethical integrity of the medical profession. (In Re Quilan Revisited: The Judicial Role in Protecting the Privacy Right of Dying Incompetents: (1988) 15 Hast. Cnst L.Q. 479, 484-486)”

The competent patient taking an informed decision is acceptable. However, O’ Flaherty J, rightly, disagrees with the ‘Substituted Judgment’ doctrine of US Courts (it was also rejected by the House of Lords in Airedale). He says, he prefers the ‘best interests’ doctrine.

Blayney J, in his concurring judgment, referred to the judgment of the US Supreme Court in Cruzan v. Director, Missouri Department of Health (1990) 497 US 261 and pointed out that in the US case, Brennan and O'Connor agreed that artificial feeding amounted to 'medical treatment'. With that view, Marshall and Blackman agreed. Rehnquist CJ too treated artificial nutrition and hydration as constituting 'medical treatment'.

Denham J, while agreeing with the trial judge, referred to In re Quinlan (1976) 355 A. 2d 647 where it was stated that "the individual's right to privacy grows as the degree of bodily invasion increases".

(6) Law Hospital NHS Trust v. Lord Advocate (Scotland): (1996) SLT 848 = 1996 SCLR 491 (22<sup>nd</sup> March 1996) (Lord President (Hope), Lord Clyde, Lord Cullen, Lord Milligan and Lord Wylie). (Court of Sessions, Inner House) (Court of Five Judges)

Mrs J, a patient, had been in a persistent vegetative state (PVS) since 22<sup>nd</sup> January 1992. She had no prospect of recovery and was unable to give a valid consent to the taking of further steps. She could not see, hear, feel pain or pleasure, nor communicate by word or movement or make voluntary movements of any kind. The brain stem was alive. Breathing, cardiac function and digestion were artificially maintained. Involuntary movements of the eyes and the ability to make sounds gave the impression of apparent wakefulness. This was followed by periods of apparent sleep with eyes closed. She was now permanently insensate. The consultant physician and two neurologists were of the view that her condition was hopeless and there were no useful avenues of treatment. The curator-ad-litem represented her.

Her husband, daughter and two brothers agreed that life-sustaining and medical treatment should be discontinued. The patient was, however, unable to give consent.

The present action was raised as an ordinary action by the NHS Trust, in the Outer House and was reported to the Inner House. The declarations sought for were similar to those in Airdale. In England where the courts parens patriae jurisdiction was abolished, the courts innovated a procedure whereby declarations in regard to termination of life support could be granted. In Scotland, as the parens patriae jurisdiction remained, a declaratory remedy was sought under the parens patriae jurisdiction. The Lord Ordinary before whom the action came up, reported to the Inner House, seeking that rulings be given, including a ruling about the competency of the action.

The Lord President (Lord Hope) referred to the modern invasive procedures available in medical technology to keep a person alive by artificial ventilation and artificial nourishment, a patient who would have otherwise died a normal death. Where the patient was of full age and capable of understanding and was able to consent to the procedures if medical advice stated that they were for his or her benefit, a patient could refuse medical treatment on the basis of a right to self-determination which provided the solution to all problems, at least so far as the court was concerned. It was not in doubt that a medical practitioner who acts or omits to act with consent of his patient requires no sanction of the court.

The problems arose where the patient was not of full age or lacked the capacity to consent to what was being proposed. The law had to decide issues firmly rather than refer merely to moral obligations of the doctors, because a 'deliberate omission which causes death may also expose the medical practitioner to the allegation that his conduct is criminal'. It was not a sufficient reassurance for a doctor, in the present state of the law, to be told that his proposed conduct was medically ethical. He was entitled to know about civil or criminal liability under the law.

The Lord President stated that in Airedale, the House of Lords decided on grounds of public policy, that the courts should, by declaration, provide to doctors faced with such decisions, clear rulings as to whether the course which they propose to adopt was or was not lawful. The medical profession was entitled to look to the courts. This view had the support of the Scottish Law Commission in its Report on Incapable Adults (Scot Law Com No.151, para 5.86).

He said that a declaration may be sought in the manner in which it was done in Airedale and relief could be claimed as in the Practice Note of March 1994 by the Official Solicitor (1994 (2) All ER 413).

After holding that the Lord Ordinary had parens patriae jurisdiction in Scotland and that a declaratory relief was sought as conceived by the Scottish Law Commission he said that the application was maintainable whether or not, there were objectors to such an application.

But, the more important issue that was raised by the Lord Advocate was whether a virtual declaration could be sought whether a particular proposed conduct was a crime or not in as much as that would amount to an intrusion into the fields of criminal courts which have exclusive jurisdiction to decide the questions (in Scotland, the High Court of Justiciary).

Of course, in the present case, as the doctors, parents, relatives were all in favour of withdrawal of life support, there was no need to seek a declaratory relief. But, in any event, the Lord Ordinary could grant a declaration for the purpose of giving ‘guidance and reassurance’ to the pursuers and to the patient’s medical practitioner about the legal consequences of terminating the life sustaining treatment, insofar as it was competent for such guidance to be given by “this court”. Without such guidance, they would not be able to discontinue the treatment. Otherwise, the risks were great. In fact, their risks had not diminished because of the fact that the curator-ad-litem to Mrs. J had expressed in his affidavit that it was in the patient’s best interests that her treatment and care be continued and not discontinued as proposed. The proposed declaration did not seek any relief that particular conduct be declared to be not criminal. “What it seeks is a declarator that the pursuers and the medical practitioner ‘may lawfully discontinue’ the treatment”.

But, the word ‘lawful’ in the declaration sought, without qualification implies an assertion that the conduct was not only not a breach of duty according to the civil law but that it was also not a crime known the law of Scotland’. In Airedale NHS Trust v. Bland, the House of Lords approved of a declaration in these terms after considering among other things whether

the proposed discontinuance of the treatment was unlawful because it would constitute an offence. Sir Stephen Brown (at p.805), in the Family Division, said that he did not consider it appropriate to make any declaration with regard to any possible consequences so far as the criminal law was concerned. In the context of his opinion, the declaration that the course proposed was lawful meant that it was lawful ‘according to civil law’. But in the Court of Appeal and the House of Lords, the Official Solicitor also proposed the question whether the proposed action would be criminal in nature. Lord President then says:

“Lord Goff of Chieveley (at p.862 G) and Lord Mustill (at pp.888E-889F) expressed strong reservation about the granting of a declarator as to criminality in a civil case. Lord Mustill pointed out that the decision in that case would in any event not create an estoppel in the criminal courts which would form a conclusive bar to future prosecution. Nevertheless, they did proceed to decide the issue and it is clear from all the speeches that their Lordship were of the view that the conduct which was proposed would not amount to crime according to the law of England.”

Having said that, the Lord President doubted if any declaration that might be granted would preclude the criminal court from going into the question. He stated:

“while a declaration can be given about the civil law in this process, it is beyond the jurisdiction of this court to say whether the proposed course of conduct is or is not criminal. Nevertheless, I consider that

it is not open to this court to assert that a proposed course of conduct is or is not criminal by means of a bare declaration. If it is necessary for the court to resolve this issue in order to decide whether or not a party to the action is entitled to some other civil remedy, then this will be within its competence. The decision about the criminality of the conduct can be said to be ancillary to the provision of a remedy which it is within the power of this Court to provide. But a bare declaration that a course of conduct, or a proposed course of conduct is, or is not criminal, is in a different position. The only purpose to be served by such a declaration would be in regard to the operation of the criminal law, which lies beyond the jurisdiction of the Court.”

In Scotland, the civil jurisdiction alone is with the Court of Sessions (which made this reference to the Inner House while the criminal jurisdiction is with High Court of Justiciary). He, however, says:

“We are not being asked to intervene in (any) criminal proceedings which have already been instituted or to interfere in some other way in the business which is being conducted in the High Court of Justiciary. What we are being asked to do is to authorize the Lord Ordinary to issue a declaration as to the criminality of the proposed conduct, with knowledge that this will not bar proceedings in that Court but in the hope that it will in practice ensure that no prosecution will be taken there.”

There are, he says, strong reasons of policy for leaving the definitions of what amounts to ‘Criminal conduct’ to be decided by the criminal Courts.

“Any declaration which we might make would not be binding on the High Court of Justiciary. Nor would any declaration which we might authorize be binding on the Lord Advocate, who would be entitled in the public interest, irrespective of what we might say, to bring the matter before the criminal courts, to which the issue clearly belongs because the function of the criminal law is to regulate conduct by the imposition of criminal sanctions.”

Another distinction peculiar to Scotland, as being a second reason, was stated as follows:

“A further point which ought not to be overlooked is that, while an appeal lies to the House of Lords from the Court of Sessions, the High Court of Justiciary is the Supreme Court of Criminal Jurisdiction in Scotland, from whose decisions no appeal to the House of Lords is competent. In Mackintosh, Lord Advocate (1876) (3) 12 (HL) 34, it was held that it would be contrary to the provisions of Art 19 of the Act of Union, 1707 for decisions of the High Court of Justiciary to be held to be other than final and conclusive on that Court. In my opinion, we should leave it to the High Court of Justiciary to define what conduct is or not criminal under the law of Scotland. It is not for the Court of Session to explore questions relating to the scope of the criminal law which have not already been established by decision in the High Court of Justiciary.”

For these reasons, while I consider that the Lord Ordinary may properly grant a declaration in this case, the terms of the proposed declaration will require to be amended to make it clear that the declaration is given in regard to the civil consequences of the proposed conduct. Some other solution must be found as to how the re-assurance in regard to the criminal consequence of that conduct can be given to the pursuers and the medical practitioner.”

As regards the existence of parens patriae jurisdiction, the Lord President stated that, it was jurisdiction of the Crown which, as stated in Airedale, could be traced to the 13<sup>th</sup> century. It laid down a duty to protect the person and property of those who were unable to protect themselves, such as minors and persons of unsound mind. But in England and Wales, the jurisdiction survives only for minors and so far as persons of unsound mind were concerned, it ceased to exist because of the Mental Health Act, 1959 and the revocation ‘by Warrant under the Sign Manual’ of the Warrant dated 10.4.1956, by which such Jurisdiction in relation to unsound persons was assigned to the Lord Chancellor and Judges of the Chancery Division of the High Court. In Airedale, the House of Lords, therefore, laid down that a declaration could be granted under inherent powers in the case of persons other than minors, that “the proposed discontinuance of treatment was in the patient’s ‘best interests’.” In Scotland there was no such problem in regard to parens patriae jurisdiction as sec 1 of the Exchequer Court (Scotland 1 Act, 1856) had not been repealed though sec 19 was repealed.

The Lord President referred to the Canadian case in Mrs. E vs. Eve 1986 (2) SCR 388, as one where the parens patriae jurisdiction was held by

L'a Forest J (p 410) as being available for a Court under its inherent powers, to permit non therapeutic sterilization of persons mentally incompetent, (referred to in In re B (A Minor) (Wardship : Sterilisation): 1988 (1) AC 199 (at p 211). In Ireland, in 'Ward of Court, In the matter of a' (1995(2) ILR M 401 too, the Court could hold that a Judge of the High Court could exercise his parens patriae jurisdiction, (as exercised by the Lord Chancellors of Ireland prior to 1922 and now vested in the President of the High Court) to give consent on behalf of a ward in persistent vegetative state. It is not the practice in Scotland to treat persons of unsound mind as wards of Court.

Finally, the Lord President held that an application can be presented to the Outerhouse by the Area Health Authority or NHS Trust in whose care the patient was for the time being, or by any relative of the patient within the meaning of sec. 1 of the Damages (Scotland) Act 1976. Application would be seeking treatment withdrawal. The Lord Advocate, the Area Health Authority or NHS Trust and relatives of patients have to be heard. Medical reports, proposed treatment or proposals for discontinuance of medical support should be sought for. In view of the advice given by BMA guidelines on Treatment Decision for Patients in Persistent Vegetative State (July, 1993), the life prolonging treatment must continue until the patient has been insentient for at least 12 months. Details of PVS and the treatment must be given. Advance directives of patient, if any, should be stated, whether it is in writing or not. It must be prayed that a curator ad litem be appointed to protect the patient's interests. Case should be heard in chambers without intimation on the notice boards, unless public interest requires. There is no need to seek a declaration. The Court's parens patriae

jurisdiction can be invoked. At least two medical reports are necessary on the patient's condition, and the application must specify the treatment proposed or to be discontinued to allow the patient to die in dignity.

(Lord Clyde, Lord Cullen, Lord Milligan wrote separate judgments. Lord Wylie agreed with the Lord President).

(7) In re B (A Minor) (Wardship: Sterilisation): 1988(1) AC 199

This was a case of a mentally retarded 17 year old ward and her ability to understand speech was that of a 6 year old child. Her mother and staff at the Sunderland Borough Council where she lives, became aware that the girl showing signs of sexual awareness and could become pregnant. The Council applied to the Court for an order that B, a ward of Court, should be allowed to undergo sterilisation compulsorily. She would panic and require heavy sedation during normal delivery, which carried risk of injury to her. Caesarian was deemed inappropriate. She may not care for the child as a mother. Bush J gave leave for sterilisation.

On appeal, the said decision was confirmed. On further appeal, the House of Lords also confirmed the decision. It said that a court exercising wardship jurisdiction, when reaching a decision on an application to authorize an operation for the sterilisation of a ward, was concerned only with one primary and paramount consideration, namely, the welfare and best interests of the ward; that accordingly, on the evidence adduced of the risk of B becoming pregnant, of the lack of effective contraceptive which required being formulated for her, of the trauma that childbirth would bring to her and to prevent the risk of injury to her or her child, and of her

inability even to desire or care for a child, the operation would be in the best interests of the child.

Lord Templeman, however, observed that sterilization of a girl under 18 shall not be undertaken except with permission of a Judge of the High Court. Or else, a doctor sterilising a child merely on basis of her parent's consent, may become liable criminally.

The majority disagreed with La Forest J of the Canadian Supreme Court In re Ere: (1986) 31 DLR (4<sup>th</sup>) 1 where it was said that the Court could never give consent to sterlisation of a minor. It approved the decision of Heilborn J in In re D (A. Minor)(Wardship: Sterlisation) 1976 Fam 185 that a girl could be sterilised if pregnancy could be an unmitigated disaster.

8. In re F (Mental Patient: Sterilisation) : 1990(2) AC 1. Here the patient was not a minor, hence parens patriae jurisdiction was not available, but even so, applying the inherent power doctrine, the same test, namely, the test of "best interests of the patient" was applied by Lord Brandon of Oakbrook (at p.64).

Here the woman was 36 years old, was mentally handicapped and unable to consent to an operation. She became pregnant. The hospital staff considered that she would be unable to cope with the effects of pregnancy and giving birth to a child and that, since all other forms of contraception were unsuitable and it was considered undesirable to further her limited freedom of movement in order to prevent sexual activity, it would be in her best interests to be sterilised. Her mother who was of the same view moved

the Court for a declaration that such operation would not amount to an unlawful act by reason of the absence of her consent. The trial Judge and the Court of Appeal accepted that the lady be sterilised.

On appeal, the House of Lords affirmed the decision. It referred to Bolam vs. Friern Hospital Management Committee 1957(1) WLR 582 and In re B (A minor)(Wardship: Sterilisation): 1988 A.C 199. It said that it was open to the Court under its 'inherent' jurisdiction to make a declaration that a proposed operation was in the patient's best interests, where the patient was an adult but unable to give informed consent, where the purpose was to prevent the risk of her becoming pregnant.

Though parens patriae jurisdiction was abolished in England by statute in the case of mentally ill patients, the trial Judge and the Court of Appeal held that the Court could give consent under inherent jurisdiction.

The House of Lords held that though the parens patriae jurisdiction was not available because it was abolished in the case of mentally-ill patients by statute, the Court still had inherent jurisdiction to grant a declaration that sterilization of F in the circumstances of the case, would not be unlawful if it was in the best interests of the patient. Though there was no need to obtain a declaration in as much as doctors could perform the surgery on the ground that it was in the best interests of such a patient, but in practice the Court's jurisdiction should be invoked whenever it was proposed to perform such an operation, 'since a declaration would establish, by judicial process whether the proposed operation was in the best interests of the patient and therefore lawful'. In determining whether the proposed

operation was in the best interests of the patient, the Court could apply the established test of what would be accepted as appropriate treatment at the time by a reasonable body of medical opinion skilled in the particular form of treatment. At common law, a doctor can lawfully operate on or give other treatment to adult patients who are incapable of consenting to his doing so, provided that the operation is in the best interests of such patients. The operation or treatment will be in their best interests 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. (Lord Griffith dissented)

Among the cases considered are Bolam 1957 (2) All ER 118 Re D (a minor)(wardship: sterilization) : (1976)(1) All ER 326, Re Eve (1986) 31 DLR (4<sup>th</sup>) 1 (Canadian Supreme Court) Re Grady (1981) 85 NJ 235 (NJ SC); Re Jane (1988) (Australian Family Court), Marshall vs. Curry (1933) 3 DLR 260 (NS SC); Murray vs. McCarthy : 1949(2) (DLR 422 (BC, SC); Schlocndorf vs. Society of New York Hospital (1914) 211 NY 123 (NY Ct of Apps): & other cases of English Courts. The main judgment is by Lord Brandon of Oakbrook and Lord Goff of Chieveley. (The judgment of the Court of Appeal was rendered by Lord Donaldson of Lynton MR, Neill & Butter-Sloss LJJ).

Three cases where the Court granted permission for sterilisation of mentally incompetent persons who could not give consent were referred to: Re T (14<sup>th</sup> May 1987, unrep) Per Latey J; Re X (1987, Times, 4<sup>th</sup> June, per Reeve J) and T vs. T: 1988 (1) All ER 613 (Wood J).

The House of Lords referred to Cardozo J in Schloendorff vs. Society of New York Hospitals (1914) 211 NY 123 (126) to the following effect (in respect of a competent patient):

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits assault.”

This was reiterated by Lord Reid in S vs S, W vs. Official Solicitor (1970) (3) ALL ER 107 (HL).

In Re Grady (1981) 85 NJ 235 (US) and in Re Jane (22<sup>nd</sup> Dec 1988) (Australia, Nicholson CJ) it was observed that it is of importance that the patient, - (there a minor) - must be represented by some disinterested third party.

Lord Hailsham LC, dissented from the view of La Forest J in Re Eve (1986) 31 DLR (4<sup>th</sup>) page 1 (though, on facts that decision may be correct)) where it was held that (p 32) that sterilization ‘should never be authorized for non-therapeutic purposes’ and described it as unconvincing and in startling and contrary to the welfare principle which should be the first and paramount consideration in wardship cases.

Lord Templeman, however, stated that in such cases the concerned persons must approach the High Court and if sterilization is done without consent of Court, the doctors will be liable for criminal, civil or professional

proceedings, notwithstanding that the doctor had the consent of the child's parents.

(8A) Practice Note by Official Solicitor: 1994(2) All ER 413: Withdrawal of treatment – Insensate patient – patient in persistent vegetative state. Sanction of High Court required before treatment terminated – confirmation of diagnosis.

This Practice Note was issued by the Official Solicitor mentioning the procedure to be followed while seeking declaratory relief. The form of the declaration is also given in the Practice Note.

The Note states that termination of artificial feeding and hydration for patients in a PVS requires, virtually in all cases, sanction of High Court Airedale and Frenchay Healthcare NHS Trust vs. S: 1994(2) All ER 403 are quoted. (That it need not be in all cases was laid down by the Court of Appeal, in Re Burke, (2005) EWCA (Civ) 2003)

The diagnosis: The Medical Ethics Committee of British Medical Association issued guidelines in July 1993. A PVS diagnosis should not be confirmed unless the patient is in that state for 12 months. Such a decision must be preceded by rehabilitative measures such as arousal programmes. (Airedale and Report of House of Lords Select Committee on Medical Ethics HC paper (1993-94) 21-I).

Procedure for application to court is detailed on the basis of procedure indicated by HL in F v. West Berkshire Health Authority: 1989

(2) All ER 545 (HC) and Official Solicitor's Practice Note of May 1993: 1993 (3) All ER 222. (The form of declaration to be asked is also set out in the present Practice Direction).

Parties: Applicants may be either next of kin or relevant Area Health Authority/NHS Trust/(which in any event ought to be a party). The views of next of kin are very important and should be made known to court. The Official Solicitor should be invited to act as guardian ad litem of the patient.

The evidence: There should be at least two neurological reports on the patient, one of which will be commissioned by the Official Solicitor. Other medical evidence, such as evidence about rehabilitation or nursing care, may be necessary.

The views of the patient if previously expressed, either in writing or otherwise are important and the High Court may determine the effect of a purported advance directive as to future medical treatment (Re T: 1992 (4) All ER 649).

(8B) Practice Note 1996 (4) All ER 766

This Practice Note deals with withdrawal of treatment to insensate patients and patients in persistent vegetative state. It requires sanction of High Court Judge before treatment is terminated. It requires confirmation of diagnosis from two independent reports from neurologists or other doctors experienced in assessing disturbances of consciousness. The duties of doctors making the diagnosis as reported in the Report of the Working Group of Royal College of Physicians is set out. It also states that the

views of the patients and others have to be obtained and will be an important component of the decision of the doctors. For a detailed account of the practice direction including the manner in which applications have to be made to the Court, one may refer to the Practice Note set out by the Official Solicitor Act in 1996 (4) All ER 766.

(9) Re T (adult: refusal of medical treatment): 1992 (4) All ER 649=1992 (3) WLR 782

(Lord Donaldson of Lynton, Butler-Sloss and Staughton LJJ) (d. 30.7.92)

The case related to an adult patient, a lady T, who was injured in an accident on 1.7.92. She was 34 weeks pregnant and required blood transfusion. She was brought up by her mother, who was a Jehovah's witness, but the patient was not herself a member of that religious sect. The patient told the staff nurse after a private conversation with her mother, that it was sinful to have blood transfusion according to the beliefs of that sect. She then blindly signed a form of refusal of consent to blood transfusion after the caesarian operation. The consultant, therefore, hesitated to give her blood transfusion and put her on a ventilator and some drugs. Her father and her boyfriend applied to the court in an emergency hearing for authorization of blood transfusion, and the judge authorized blood transfusion and stated that, in the circumstances prevailing, it was not unlawful to do so and was in the "best interests" of the patient. The learned Judge observed that at the emergency stage, the patient had not objected and hence the blood transfusion at that stage was lawful.

On appeal by T, the Court of Appeal observed that certain earlier decisions cited by Counsel were distinguishable and as the patient was not a minor, permission of Court was not necessary to give blood transfusion.

It was further held that although prima facie, every adult had the right and capacity to decide whether he or she would accept medical treatment, even at the risk of permanent injury to health or premature death, and regardless of whether the reasons for refusal were rational or irrational, or were unknown or non-existent, still if an adult did not have the capacity, at the time of the purported refusal and continued not to have that capacity, or if his or her capacity to make a decision had been overborne by others, it was the duty of doctors to treat him in whatever way they considered, in the exercise of their clinical judgment, to be in his best interests.

It was held, on the facts, that the doctors had been justified in disregarding T's instructions and in administering blood transfusion as a matter of necessity since the evidence showed that T had not been fit to make a genuine decision because of her medical condition and that, in fact, she was subjected to the undue influence of her mother, which vitiated her decision to refuse blood transfusion. The appeal was dismissed.

Lord Donaldson MR & Butter Sloss LJ held that

(1) On behalf of a patient who is physically and mentally capable of exercising a choice but who is not in a position to make such a decision because, for example, he is unconscious, his next of kin has no legal right to consent or to refuse consent to medical treatment on behalf of the patient.

However, to seek the consent of the next of kin is not an undesirable practice if the interests of the patient will not be adversely affected by any consequential delay, since consultation with the next of kin may reveal that the patient has made an anticipating choice whether to accept or refuse specific treatment and, e.g. a blood transfusion, which if clearly established and applicable in the circumstances, will bind the medical practitioner.

(2) The standard forms of refusal to accept blood transfusion used by hospitals should be redrafted to separate the disclaimer of legal liability (on the part of the hospital) from the declaration by the patient of his decision not to accept a blood transfusion so as to bring the possible consequences of a refusal forcibly to the patient's attention.

(3) A patient should know in broad terms the nature and effect of the medical procedure to which consent is given or refused. But, although doctors are under a duty to give the patient appropriate full information as to the nature of the treatment and the likely risks (including any special risks attaching to the treatment being administered by particular person), failure to perform that duty will only amount to negligence but does not as such vitiate the consent or refusal. However, misinforming a patient, whether innocently or not, and withholding information which is expressly or impliedly sought by the patient, will vitiate either a consent or a refusal – (a) If, in a potentially life-threatening situation or one in which irreparable damage to the patient's health can be anticipated, doctors or hospital authorities are faced with a refusal of an adult patient to accept essential treatment, they should both in the public and the patient's interest, at once

seek a declaration from the court as to the lawfulness of the proposed treatment and it should not be left to the patient's family to take action.

The learned judges referred to the following passage from the decision of the Ontario Court of Appeal in Malette v. Shulman: (1990) 72 OR (2d) 417 (a blood transfusion case where it was given to an unconscious patient carrying a card that she was a Jehovah's witness). There Robins JA stated (at p.432):

“At issue here is the freedom of the patient as an individual to exercise her right to refuse treatment and accept the consequences of her own decision. Competent adults, as I have sought to demonstrate, are generally at liberty to refuse medical treatment even at the risk of death. The right to determine what shall be done with one's body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority.”

Robin JA excluded from consideration, the interest of the State in protecting innocent third parties and preventing suicide.

(10) Re C (adult: refusal of medical treatment: 1994 (1) All ER 819  
(Thorpe J) (14.10.93) : C-Test:

A 68 year old male patient suffering from paranoid schizophrenia, developed gangrene in a foot during his confinement in a secure hospital while serving a 7-year term of imprisonment. He was removed to a general hospital where the consultant surgeon opined that if the leg below the knee was not amputated, the chances were 15% of survival and he would most likely die. C refused amputation. A solicitor was called in the meantime, there was some improvement due to drugs, still the need for amputation due to fresh gangrene attack at a future date could not be ruled out. The hospital authorities moved the court for permission to amputate the leg below knee, contending that the decision of the patient refusing amputation was impaired by his mental illness and that he failed to appreciate the risk of death.

It was held that the High Court, in exercise of its inherent jurisdiction, could give directions by way of injunction/declaration in respect of an individual not capable of refusing/consenting to medical treatment (including future medical treatment). However, the question to be decided was whether it had been established that his capacity had been so reduced by his chronic mental illness and that he did not sufficiently understand the nature, purpose and effects of the preferred medical treatment. That in turn depended upon whether he had comprehended and retained information as to the proposed treatment, had believed it and had weighed it in the balance

when making a choice (known as C Test). This was the test of ‘competency’.

Thorpe J described competency of patient as follows:

“I consider helpful Dr E’s analysis of the decision-making process into three stages: first, comprehending and retaining treatment information, secondly, believing it and thirdly, weighing it in the balance to arrive at choice.”

(C-Test)

On facts, it was held that amputation should not be made, as his decision making was not so impaired by his schizophrenia. The presumption in favour of his right to self-determination was not displaced. Re T (adult: refusal of medical treatment) 1992 (4) All ER 649 and Airedale 1993 (1) All ER 821 (HL) were applied.

(11). Frenchay Healthcare NHS Trust v. S: 1994 (2) All ER 403 (CA)

(Sir Thomas Bingham MR, Waite and Peter Gibson LJJ) (14.1.1994)

S, a healthy adult, in June 1991, took a drug overdose which resulted in acute and extreme brain damage. Medical treatment was of no avail. Until June 1993, he was fed through a nasogastric tube as the only practicable way of feeding him and later by a gastronomy tube through the stomach wall. The gastronomy tube got removed due to his movement and a fresh operation to re-insert it was likely to result in his death according to the doctors. They felt he should be allowed to die a natural death.

The hospital moved the High Court as a matter of urgency for a declaration authorizing it not to replace the gastrostomy tube. The judge granted the declaration arising in the patient's best interests. On appeal by the official solicitor, the Court of Appeal held that the judge was right and that the hospital need not replace or reinsert the tube.

Sir Thomas Bingham MR held that the question which the court had to determine, in an application for permission not to continue treatment to a PVS patient was to consider what was in the 'best interests' of the patient. Though the court had power to review the medical opinion and was not bound to accept it in all cases or circumstances placed before it did not warrant it, the court would be reluctant to place those treating the patient in a position of having to carry out treatment which they considered to be contrary to the patient's best interests unless the court had real doubt about the reliability, bona fides or correctness of the medical opinion in question. Airedale was applied.

It was further held that where a hospital seeks to discontinue treatment to a PVS, as a general rule, the hospital must apply to the court and obtain a declaration that it was proper to do so, and such an application should be preceded by a full investigation with an opportunity for the official solicitor, as the representative of the patient, to explore the situation fully, to obtain independent medical opinion for himself and to ensure proper material is placed before court. Nevertheless, emergency situations will arise in which an application to the court is not possible, or where, although an application to court is possible, it will not be possible to present

the application in the same leisurely way as in the case where there is no pressure of time. Re C:

(12). Re Y (Mental capacity: Bone Marrow Transplant) (1997 (2) WLR 556) (14.6.1996) (Connel J)

A 25 years old plaintiff and her elder sister (the defendant) came from a very close supportive family. The plaintiff suffered a bone marrow disorder. Since 1984, the plaintiff had undergone extensive chemotherapy (i.e. for 12 years). There had been recent deterioration in plaintiff's condition and there was a strong likelihood that her situation would progress to acute myeloid leukemia in next three months. The only feasible prospect was a bone marrow transplant from her sister (defendant). The defendant was severely mentally and physically handicapped and was incapable of giving consent to bone marrow transplant. Plaintiff sought a declaration that two preliminary blood tests and a conventional bone marrow harvesting operation under general anaesthetic could lawfully be taken from the defendant, despite the fact that defendant could not give her consent.

The learned judge allowed the application stating:

(1) The test in such case was whether it was in the best interests of the defendant for the procedure to take place. The fact that the process would benefit the plaintiff was not relevant, unless, as a result of the defendant helping the plaintiff, the best interests of the defendant were served.

(2) Without any transplant, the plaintiff's prospects for survival were poor and her condition was deteriorating fast. If the plaintiff died, this would have adverse effect on the mother of the parties with whom the defendant had a closer relationship than with any other relative. In particular, the mother's ability to visit the defendant would be handicapped significantly. The defendant would be harmed by the reduction in or loss of contact to her mother.

(3) It was to the "emotional, psychological and social benefit" of the defendant to act as donor to her sister because, in this way, her positive relationship with her mother was most likely to be prolonged. The disadvantages to the defendant of the harvesting procedure were very small. The bone marrow donated by the defendant would cause her no loss and she would suffer no real long-term risk.

Apart from referring to Airedale and other judgments of UK Courts, Connel J referred to an American case in Curran v. Bosze: (1990) 566 NE 2d 1319, where an application designed to permit bone marrow harvesting from twins for the benefit of their brother was considered. The Supreme Court of Illinois concluded that the doctrine of 'substituted judgment' (rejected in Airedale) was inapplicable but that the best interest test applied. Calvo J stated in that case that the benefit the donor will get and mostly it is in enhancing some close ties between donor or donee or their mother. He said:

"In each of the foregoing cases where consent to the kidney transplant was authorized, regardless whether the authority to consent was to be

exercised by the court, a parent or a guardian, the key inquiry was the presence or absence of a benefit to the potential donor. Notwithstanding the language used by the courts in reaching their determination that a transplant may or may not occur, the standard by which the determination was made was, whether the transplant would be in the best interests of the child or incompetent person.

The primary benefit to the donor in these case arises from the relationship existing between the donor and the recipient. In Strunk, the donor lived in a State institution. The recipient was a brother who served as the donor's only connection with the outside world. In both Hart and Little, there was evidence that the sibling relationship between the donor and the recipient was close.

Connel J then quoted the further observations of Calvo J in Curram v. Bosze to the following effect:

“..... there must be an existing, close relationship between the donor and recipient. The evidence clearly shows that there is no physical benefit to a donor child. If there is any benefit to a child who donates bone-marrow to a sibling, it will be a psychological benefit. According to the evidence, the psychological benefit is not simply one of personal, individual altruism in an abstract theoretical sense, although that may be a factor.

A psychological benefit is grounded firmly in the fact that the donor and recipient are known to each other as family. Only where

there is an existing relationship between a healthy child and his or her ill-sister or brother, may a psychological benefit to the child from donating bone marrow to a sibling realistically be found to exist. The evidence establishes that it is the existing sibling relationship, as well as the potential for a continuing sibling relationship, which forms the context in which it may be determined that it will be in the best interests of the child to undergo bone marrow harvesting procedure for a sibling’.

And finally Calvo J stated:

“The guardian ad litem for the twins recommends that it is not in the best interests of either Alisu or James to undergo the proposed bone marrow harvesting procedure, in the absence of an existing close relationship with the recipient (their half-brother) and over the objection of their primary care taker (the mother). Because the evidence presented supports this recommendation, we agree”.

Connell J while allowing the application considered that, because of these principles, the benefit occurring to the donor is of equal, if not greater, importance.

(13). Gillick vs. West Norfolk Wisbech Area Health Authority: = 1986 AC 112; 1985(3) All ER 402 (HL): (‘Gillick Competence’)

The case related to a slightly different problem but certain principles laid down therein regarding ‘consent’ have application in cases of

withdrawal of life support. The test laid down in this case is known as ‘Gillick Competence’.

In this case, the plaintiff who had five daughters under the age of 16, sought an assurance from the Local Area Health Authority that her daughters would not be given advice and treatment on contraception without the plaintiff’s prior knowledge and consent while they were under 16. This she did keeping in mind the circular issued by the Dept. of Health and Social Security that, while normally a doctor should not advise use of contraceptives to girls under 16 without consent of the parents, in exceptional circumstances if they advised in that regard without the consent of the parents, it may not be unlawful keeping in view the principle of confidentiality between doctors and their clients. Initially, she approached the local Area Health Authority but they refused to respond. She then filed the present action. According to her, the circular amounted to advice to doctors to commit the offence of causing or encouraging unlawful sexual intercourse between males and girls under 16, contrary to sec 28(1) of the Sexual Offences Act, 1956 or the abetting of it.

The learned Judge (Woolf J, as he then was) held that a doctor acting as per the circular would not be committing any offence of causing or encouraging unlawful sexual intercourse. The Court of appeal, however, reversed the judgment (1985(1) All ER 533).

The House of Lords was approached by the Deptt. Of Health and the appeal was allowed. It was held that, having regard to the reality that a child became increasingly independent as it grew older, parental authority

can be recognized only as long as they were in need of the protection and such rights yielded to the child's right to make its own decisions when it (or) reached a sufficient understanding and intelligence to be capable of making up its own mind. A girl under 16 did not, merely by reason of her age, lack legal capacity to consent to contraceptive advice and treatment by a doctor. (Lord Templeman dissented).

It was held by the majority that a doctor, who in exercise of his clinical judgment gave contraceptive advice and treatment to a girl under 16 without her parents' consent, did not commit any offence under the 1956 Act, because the bona fide exercise of a clinical judgment by the doctor negated mens rea which is an essential ingredient of those offences on this aspect. (Lord Brandon dissented).

Therefore, a doctor had such discretion provided the girl had reached an age where she had a sufficient understanding and intelligence to enable her to understand fully what was proposed, that being a question of fact in each case. The Deptt's circular could be followed by a doctor without involving him in any infringement of parental rights or breach of criminal law. (Lord Brandon and Lord Templeman dissenting).

(14). Re (A minor)(Wardship: Medical Treatment): 1991(4) All ER 177 (CA)(Lord Donaldson of Lynton, Strangton & Farquharson LJJ)

R, a 15 year old who had psychotic problems was placed in a children's home. She experienced visual and auditory hallucinations. She was violent too and paranoid. Ward's mental condition was fluctuating

between normal behaviour and psychosis. The local authority placed her in an adolescent psychiatric unit where she was sedated from time to time with her consent. This it did because the patient was behaving in a paranoid, argumentative and hostile manner. Although she had clear intervals when her mental illness was in recession, the prognosis was that if the medication was not administered, she would return to her psychotic state. However, in rational and lucid periods, when she had sufficient understanding to make the decision, she objects to taking the drugs. In those circumstances, the Local Authority refused to authorize the administration of drugs against her will, while the unit was not prepared to continue to care for her unless it had authority to administer appropriate medication to control her. The Area Local Authority commenced wardship proceedings and applied for leave for the unit to administer medication, including anti-psychotic drugs, whether or not the ward consented. The question arose (i) whether the Judge had power to override the decision of the ward who was a minor to refuse medication and treatment irrespective of whether the minor was competent to give her consent and (ii) whether he had the requisite capacity to accept or refuse such medication or treatment.

Walter J granted the application, holding that although a wardship judge could not override the decision of a ward who had the requisite capacity, on the facts, the ward did not have the capacity. The Official Solicitor as guardian-ad-litem of the ward appealed, contending that if a child had the right to give consent to medical treatment, the parents, (and a fortiori) the wardship Court's right to give or refuse consent was terminated. On appeal, the Court of Appeal confirmed the judgment

holding that the Judge was right in granting the application for the unit to administer medication irrespective of whether the ward consented.

In the course of judgment, Lord Donaldson MR referred to Gillick's case (1985)(3) All ER 402 and referred to, what is now known as "Gillick Competence". He said:

"The test of 'Gillick Competence', although not decisive in this case, is nevertheless of general importance . . . . The House of Lords, in that case, was quite clearly considering the staged development of a normal child. For example, at one stage it (the patient) will be quite incapable of deciding whether or not to consent to a dental examination, let alone treatment. At a later stage, it will be quite capable of both, but incapable of deciding whether to consent to more serious treatment. But there is no suggestion that the extent of this competence can fluctuate upon a day-to-day or week-to-week basis. What is really being looked at is an assessment of mental and emotional age, as contrasted with chronological age, but even this test needs to be modified in the case of fluctuating mental disability to take account of that misfortune. It should be added that, in any event, what is invoked is not merely an ability to understand the nature of the proposed treatment – in this case compulsory medication – but a full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects and, equally important, the anticipated consequences of a failure to treat. . . .

But even if she was capable on a good day of a sufficient degree of understanding to meet the Gillick criteria, her mental

disability, to the cure or amelioration of which the proposed treatment was directed, was such that on other days, she was not only 'Gillick incompetent', but actually sectionable. No child in that situation can be regarded as 'Gillick Competent' and the Judge was wholly right in so finding in relation to R."

In the body of the Judgment, it was held that if a 'Gillick Competent' person consents, there can be no problem but where such person refuses, "Consent can be given by someone else who has parental rights or responsibilities. The failure or refusal of the 'Gillick competent' child is a very important factor in the doctor's decision whether or not to treat, but does not prevent the necessary consent being obtained from another competent source."

Lord Donaldson then laid down six principles, which read as follows:

- (1) No doctor can be required to treat a child, whether by the Court in the exercise of its wardship jurisdiction, by the parents, by the child or anyone else. The decision whether to treat (a patient) is dependent upon an exercise of his own profession judgment, subject only to the threshold requirement that, save in exceptional cases usually of emergency, he had the consent of someone who has authority to give that consent. In forming that judgment, the views and wishes of the child are a factor whose importance increases with the increase in child's intelligence and undertaking.
- (2) There can be concurrent powers to consent. If more than one body or person has power to consent, only a failure to or refusal of consent by all having that power will create a veto.

- (3) A 'Gillick Competent' child or one over the age of 16 will have power to consent but this will be concurrent with that of a parent or guardian.
- (4) 'Gillick Competence' is a development concept and will not be lost or acquired on a day-to-day or week-to-week basis. In the case of mental disability, that disability must also be taken into account, particularly where it is fluctuating in its effect.
- (5) The Court in the exercise of its wardship or statutory jurisdiction has power to override the decisions of a 'Gillick Competent' child as much as those of parents or guardians.
- (6) Waite J, was right to hold that R was not 'Gillick Competent' and, even if R had been (the Judge), was right to consent to her undergoing treatment which might involve compulsory modification."

(15). Re MB (Medical Treatment): 1997(2) FLR 426:

The case is quite important and deals with refusal of Caesarean operation by a pregnant lady and raises the question whether, if the refusal is to be treated as one made by a 'competent person', the doctors could be given leave to perform the Caesarean operation with a view to save the life or prevent brain damage to the foetus. Question is whether the life of the mother or of the child (to be born) has priority? The trial Judge granted permission but the Court of Appeal refused leave.

There the appellant attended the clinic when she was 33 weeks pregnant. She refused to allow blood samples to be taken because of her

‘fear of needles’. When she was 40 weeks pregnant, it was found that the foetus was in the breach position. It was explained to the patient that a normal delivery would pose serious risk of death or brain damage to the baby. She initially gave consent in writing and so did her partner but later she panicked on account of ‘needle phobia’ and withdrew consent. Finally she agreed but refused to allow anaesthesia. The health authority applied to court and the court granted leave to the gynecologist to operate on her, using reasonable force, if necessary.

On 18.2.97, after she finally refused at 9.00 pm, the hospital sought a court order at 9.25 pm and Hollis J made a declaration at 9.55 pm permitting the operation. Earlier in the day, the lady was provided with her own lawyers. After decision of Hollis J, Mr. Francis Q.C again spoke to her and she asked him to file an appeal. On the following morning, she signed another consent form and co-operated fully in the operation as well as for induction of anaesthesia. A boy child was born after the caesarian operation. The appeal was filed – perhaps to settle the issues arising in the case.

(A) Butler-Sloss LJ speaking on behalf of the Court of Appeal, agreed with the trial judge and held that

(1) patient’s consent is necessary for invasive medical treatment and that a mentally competent person was entitled to refuse medical treatment, whether for good or rational or even for irrational reasons or for no reasons at all, even where that decision might lead to his or her death. The only situation in which it was lawful for the doctors to intervene was where ‘it

was believed that the adult patient lacked the capacity to decide and the treatment was in the patient's best interests'. The court did not have the jurisdiction to take into account the interests of the unborn child at risk from refusal of a competent mother to consent for medical intervention.

(Dicta of Lord Donaldson in Re T (Adult: Refusal of Treatment) sub non Re T (An Adult: Consent to Medical Treatment) and of Sir Stephen Brown (President) in Re S (Adult: Refusal of Medical Treatment) where he had to take an urgent decision, even without consulting the patient – were dissented).

(2) Medical treatment can be undertaken in an emergency even if, through lack of capacity, no consent had been competently given, provided the treatment was a necessity and did no more than was reasonably required in the best interests of the patient Re F (Mental Patient: Sterilization): 1990 (2) AC1.

(3) On the facts, the evidence of the obstetrician and the consultant psychiatrist established that the patient could not bring herself to undergo the caesarian section she desired because a panic – fear of needles dominated everything and, at the critical point she was not capable of making a decision at all. On that basis, it was clear that she was at the time suffering from an impairment of her mental functioning which disabled her and was temporarily incompetent.

Test in Re C (Refusal of Medical Treatment): 1994(1) All ER 819 applied.

(4) Furthermore, since the mother (pregnant lady) and father wanted the child to be born alive and the mother (the pregnant lady) was in favour of the operation, subject only to her needle phobia, and was likely to suffer long term damage if the child was born handicapped or dead, it must follow that medical intervention was in the patient's best interests, with the use of force if necessary for it to be carried out. In these circumstances, the judge was right in granting the declaration.

(B) On the question of capacity to decide, the Court of Appeal quoted Lord Donaldson (Re T (An Adult) (Refusal of Medical Treatment) (1993 Fam 95 (102) = 1992 (4) All ER 649 sub nom Re T (An Adult: Consent to Medical Treatment) 1992 (2) FCR 458 (460): (at p.112) (at p.470) as follows: (That was case of a pregnant lady involved in a car accident who required blood transfusion)

“Capacity to decide:

The right to decide one's own fate presupposes a capacity to do so. Every adult is presumed to have that capacity, but it is a presumption which can be rebutted. This is not a question of the degree of intelligence or education of the adult concerned. However, a small minority of the population lack the necessary mental capacity due to mental illness or retarded development (see, for example Re F (Mental Patient) (Sterilisation) 1990 (2) AC1). This is a permanent or at least a long term state. Others who would normally have that capacity may be deprived of it or have it reduced by reason of

temporary factors, such as unconsciousness or confusion or other effects of shock, severe fatigue, pain or drugs used in their treatment.

Doctors, faced with a refusal of consent, have to give very careful and detailed consideration to the patient's capacity to decide, at that time when decision was made. It may not be the simple case of the patient having no capacity because, for example, at that time he had hallucinations. It may be the more difficult case of a temporarily reduced capacity at the time when his decision was made. What matters is that the doctors should consider whether at the time he had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required. If the patient had that requisite capacity, they (doctors) are bound by his decision. If not, they are free to treat him in what they believe to be in his 'best interests'."

(C) The Court of Appeal quoted Thorpe J in Re C (Refusal of Medical Treatment) 1994 (1) FCR: 1994 (1) All ER 819, (There it was a man of 68, suffering from paranoid schizophrenia refusing to have an amputation of his leg) to the following effect:

"I consider helpful Dr E's analysis of the decision-making process into three stages: first, comprehending and retaining treatment information, secondly, believing it and, thirdly, weighing it in the balance to arrive at choice."

This is known as the 'C Test'.

(D) (i) The Law Commission of UK has proposed a similar approach in para 2.20 of its Consultation Paper 129, “Mentally Incapacitated Adults and Decision-Making”.

(ii) In 1995, the Law Commission of UK recommended in Law Com No.231 on ‘Mental Capacity’ (in paras 3.2 – 3.23) that a person is without capacity at the material time if he is unable by reason of mental disability to make a decision for himself on the matters in question either because:

(a) he is unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequence of deciding one way or another or failing to make the decision; or

(b) he is unable to make a decision based on that information.”

“Mental disability’ was defined as a disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.”

(E) Caesarian Section cases:

Butler-Sloss LJ then referred to other Caesarian Section decisions:

(a) In Tameside and Glossop Acute Services Trust v. CH: 1996 (1) 7 FLR 762, the patient was suffering from paranoid schizophrenia and was admitted under sec. 3 of the Mental Health Act, 1893. She was found to be pregnant and the foetus was in danger if the pregnancy continued. There

was overwhelming evidence that she lacked the capacity to consent to or refuse the treatment proposed. Wall J, in making the declaration sought under sec. 63 of that Act, set out the general principles which govern non-consensual treatment and applied the three-part test (the case in Re C decided by Thorpe J, called the ‘C-Test’).

(b) The next case as to caesarian section is Norfolk and Norwich Healthcare (NHS) Trust v. W: (1996) (2) FLR 613. That was a peculiar case where the lady, who was under psychiatric treatment, came to the hospital in labour denying that she was pregnant. She was in a state of arrested labour. The obstetrician considered a forceps delivery or a caesarean section had to be performed. A psychiatrist examined her and found she was not suffering from a mental disorder. He was not certain whether she was capable of comprehending and retaining information about the proposed treatment but she continued to deny she was pregnant. He was not sure if she was capable of believing the information about the treatment. He was, however, of the opinion that she was not able to balance the information given to her. This was the C test. Johnson J (at p.616) held that:

“... although she was not suffering from a mental disorder within the meaning of the statute, she lacked the mental competence to make a decision about the treatment that was proposed because she was incapable of weighing up the considerations that were involved. She was called upon to make that decision at a time of acute emotional stress; and (the) physical pain in the ordinary course of labour made

even more difficult for her because of her own particular mental history.”

The judge was satisfied that the operation was in her best interests and that, in the circumstances, the court had power, at common law, to authorize the use of reasonable force.

(c) Rockdale Healthcare (NHS) Trust v. C (unreported, 3<sup>rd</sup> July 1996) also related to a caesarian operation. During the hearing of Norfolk, above referred to, Johnson J was approached for an urgent declaration because the obstetrician considered that the caesarian section had to be carried out within an hour if the foetus was to survive and risk of damage to the patient’s health was to be avoided. The lady had previously a caesarian section and she said she would rather die than have it again. It was not possible to obtain psychiatric evidence in the time available. The obstetrician considered that the patient was fully competent. The judge had very little time and only ‘the scantiest information’ upon which to assess the patient and make a decision. Johnson J applied the C test (as laid down by Thorpe J) and found that the patient was not capable of weighing up the information that she was given, the third element of the C test. Johnson J held:

“The patient was in the throes of labour with all that is involved in terms of pain and emotional stress. I concluded that a patient who could, in those circumstances speak in terms which seemed to accept the inevitability of her own death, was not a patient who was able properly to weigh-up the considerations that arose so as to make any

valid decision, about anything of even the most trivial kind, still one which involved her own life.”

Adverting to this case, Butler-Sloss LJ commented that one may question whether there was evidence before the court which enabled the judge to come to a conclusion contrary to the opinion of the obstetrician that she was competent. Nonetheless, he made the declarations sought. In fact, the patient changed her mind and consented to the operation.

(d) Re L: (unreported, 5<sup>th</sup> Dec. 1996) is yet another case of caesarian operation. Kinkwood J was faced with an application, on facts similar to the Re MB. It was again a case of needle phobia. An urgent application was made in respect of a patient L, in her twenties who had been in labour for some hours and the labour had become obstructed. In the absence of intervention, the foetus was at risk and deterioration was inevitable and death would follow. The carrying of a dead-foetus would be injurious to the patient’s health and the removal of the foetus by surgical procedure would become necessary. An emergency caesarean section was strongly indicated. L wanted her baby to be born alive but she suffered from needle phobia and was unable to consent to the use of a needle and therefore (opposed) to the proposed course of treatment. Kirkwood J applied the C test of Thorpe J and said:

“... that her extreme needle phobia amounted to an involuntary compulsion that disabled L from weighing treatment information in the balance to make a choice. Indeed, it was an affliction of a

psychological nature that compelled L against medical advice with such force that her own life would be in serious peril.”

The learned Judge held that she was incapable of weighing the relevant treatment information in the balance and thus lacked the relevant mental competence to make a treatment decision. He further held that it was in her best interests to have the operation and he granted the declaration sought by the hospital.

(e) Butler-Sloss LJ referred also to Re S (Adult: Refusal of Medical Treatment) 1993 Fam 123 C = 1993 (1) FLR 26) where Sir Stephen Brown, President had to take a decision in a matter of ‘utmost urgency’. The hearing was brief, the lady could not be represented. The Health Authority and the hospital applied for emergency caesarean section. The Official Solicitor acted as amicus curiae. The patient’s objection was based on religious grounds. The court stated that it was approached at 1.30 pm, the hearing was at 2.00 pm and the order was at 2.18 pm. Stating that there was no direct English case at that time, he relied upon an American case in Re C (1990) 573 A 2d 1235 (1240, 1246-1248, 1252). The judge said:

“I do not propose to say any more at this stage, except that I wholly accept the evidence of Mr P as to the desperate nature of this situation, and I grant the declaration as sought.”

(F) Conclusions of Butler-Sloss LJ on “capacity of a woman to decide”:  
on medical intervention to her. (Butler-Sloss LJ)  
(caesarian cases)

“(1) Every person is presumed to have the capacity to consent to or to refuse medical treatment unless and until the presumption is rebutted.

(2) A competent woman who has the capacity to decide, may, for religious reasons, (or) other reasons, (or) for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death. In that event, the courts do not have the jurisdiction to declare medical intervention lawful and the question of her own best interests objectively considered, does not arise.

(3) Irrationality is here used to connote a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided it could have arrived at it. As Kennedy and Grubb *Medical Law* (Butterworth, 2<sup>nd</sup> Ed, 1994) point out, it might be otherwise if a decision is based on a misperception of reality (e.g. the blood is poisoned because it is red). Such a misperception will be more readily accepted to be a disorder of the mind. Although it might be thought that irrationality sits uneasily with competence to decide, panic, indecisiveness and irrationality in themselves do not as such amount to incompetence. The graver the consequences of the decision, the commensurately greater the level of competence required to take a decision: (Re T (above), Sidaway (a) 1985 AC 871 at 904, Gillick vs. West Norfolk and Wisbech Area Health Authority and Another: (1986) AC 112 169 (186).

(4) A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or refuse treatment. That inability to make a decision will occur when

- (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question:
- (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision. If, as Thorpe J observed in Re C (above), a compulsive disorder or phobia from which the patient suffers stifles belief in the information presented to her, then the decision may not be a true one. As Lord Cockburn CJ put it in Bank vs. Goodfellow (1870) LR Q B 549 (569): ‘one object may be so forced upon the attention of the invalid as to shut out all others that might require consideration’:

(5) The ‘temporary factors’ mentioned by Lord Donaldson MR in Re T (viz. confusion, shock, fatigue, pain or drugs) may completely erode capacity but those concerned must be satisfied that such factors are operating to such a degree that the ability to decide is absent.

(6) Another such influence may be panic induced by fear. Again, careful scrutiny of the evidence is necessary because fear of an operation may be a rational reason for refusal to undergo it. Fear may also, however, paralyse the will and thus destroy the capacity to make a decision.

(G) Having exhaustively analysed the principles, Butler-Sloss LJ referred to the “Guidelines from the Royal College of Obstetricians and Gynaecologist entitled “A Consideration of the Law and Ethics in relation to Court – Authorised Obstetric Intervention”. The guidelines, it was observed, provide an interesting dissertation on the decisions so far made in the Courts, a summary of the problems which arise, and give advice to the members of the medical profession who have to meet them. The Committee concluded:

“.... It is inappropriate, and unlikely to be helpful or necessary, to invoke judicial intervention to overrule an informed and competent woman’s refusal of a proposed medical treatment, even though her refusal might place her life and that of her foetus, at risk.”

The learned Judge observed that the above guideline correctly reflects the present state of the law. “The only situation in which it is lawful for the doctors to intervene is if it is believed that the adult patient lacks the capacity to decide.” “If the competent mother refuses to have the medical intervention, the doctors may not lawfully do more than attempt to persuade her. If that persuasion is unsuccessful, there are no further steps towards medical intervention to be taken. We recognize that the effect of these conclusions is that there will be situations in which the child may die or may be seriously handicapped because the mother said no and the obstetrician may not be able to take the necessary steps to avoid the death or handicap. The mother may indeed later reject the outcome, but the alternative would be an unwarranted invasion of the right of the woman to make the decision.

(16). Re D (Medical Treatment): 1998(2) FLR 10 – (Sir Stephen Brown J) (26<sup>th</sup> September, 1997)

The defendant, a man of 49 years, suffered from long-standing psychiatric illness and had spent a very large part of his life in and out of psychiatric hospitals. He suffered from chronic renal failure and required dialysis three/four times a week but his mental condition made it impossible for him to give the necessary co-operation for that treatment. The hospital authorities applied to the Court for a declaration that it would be lawful for the Trust not to impose haemodialysis in circumstances in which, according to medical opinion, it was not reasonably practical to do so as the patient was not co-operating. The official Solicitor represented the patient, obtained a doctor's opinion that in the context of the patient not being capable and not cooperative, the doctors should be protected if dialysis became impossible to be conducted.

The Court accepted the application and gave declaration that, 'notwithstanding the defendant's inability to consent to or refuse medical treatment, it is lawful as being in the best interests of the patient that the plaintiff hospital does not impose haemodialysis upon him in the circumstances in which, in the opinion of the medical practitioners responsible for such treatment, it is not reasonably practical to do so'.

(17). Re L (Medical Treatment: Gillick Competency): 1998(2) FLR 810 (Sir Stephen Brown J) (10<sup>th</sup> June 1998).

A 14 year old girl was in a life threatening condition. She rejected medical treatment involving the possibility of a blood transfusion to which, because she was a Jehovah's witness, she would not consent. She had sincere convictions and was mature for her age. The surgeon made it clear to her that he was in no doubt that the blood transfusion was necessary to save her life. The girl had not been made aware of the actual manner of death. The surgeon, however, informed the Court that she would suffer a horrible death. The hospital authority sought leave of Court to administer blood transfusion without her consent. The issue was whether she was Gillick competent?

It was held by Stephen Brown J, granting permission for blood transfusion – without her consent – that though the child's religious views may not be discussed by the Court still, there was a distinction between 'a view' of this kind and the "constructive formulation of an opinion" which occurred with adult experience; this had not happened in this child's case. It must not be overlooked that she was still a child. Also she had a sheltered life, largely influenced by the Jehovah's witness congregation. This necessarily limited her understanding of matters which were grave. She was not given all the information which it would be right and appropriate to have in her mind while deciding whether or not she could give consent. She was not 'Gillick Competent'. Re R (A Minor) (Wardship : Medical Treatment) : 1991(4) All ER 177 (CA). The Court had, therefore, to decide what was in her best interests, as on the facts, it was not only in her best interests but absolutely vital, that she received the treatment despite her lack of consent.

Per Curiam: it will be appropriate to authorise treating without her consent even if the child were 'Gillick Competent' because this was an extreme case and she was in a grave condition.

(18). Siamese Twins case: Re A (Children): 2000 EWCA 254 (Ward, Brooke, Robert Walker L JJ) (22.9.2000)

This is very lengthy judgment (about 88 pages). It raises very important medico-legal issues.

The problem there was, in the case two conjoined twins, whether invasive surgery and their separation was necessary if one of them (Jodic) could be made to live longer while it was absolutely certain that the same surgery would leave the other one, Mary, dead. Jodic was stronger and in fact she was supplying oxygen to Mary. The parents were not in favour of separating them. But, if operation was not done in six months, both will die.. The twins could not obviously decide. Johnson J granted a declaration to the hospital to separate the twins. The twins were born on 8.8.2000. Johnson J granted declaration on 25.8.2000. Johnson J took video-evidence of doctors to save time. Mary was provided nutrition by tube. If separated in six months, Mary would die but Jodic could live with a good quality of life, with defects which could be corrected. There were several medical reports on these issues placed before the Court. (pp 1 to 18).

The parents appealed. Separate judgments were delivered by the learned Judges (22.9.2000).

Ward LJ: The learned Judge referred to the fundamental principle that a person's body is inviolate. (In Re F. Mental Patient: Sterilisation: 1990(2) AC 1 (per Lord Goff) & Lord Reid in S vs. McC, W vs. W (1972) (AC 24(43)). Then there was the principle of a right of self-determination (Re F, Lord Goff referring to Cardozo J and there was also the patient's right to veto). This was recognized in Airedale : 1993 AC 789.

Treatment of the competent adult requires his consent but when he lacks competency, common law permits the principle of necessity to be applied (Lord Goff in Re F). In the case of children's parents, if they are married, they have the power to consent. (Lord Scarman in Gillick vs. West Norfolk A.H.A.: 1986(1) AC 112(184). If they are not, it is the mother's prerogative to give consent. Where parents refuse, their decision must be respected. To ignore it and operate, would be an assault (In Re R (A Minor) (Wardship consent to treat): (1992) Fam 11, per Lord Donaldson MR. But the parental right is not sovereign or beyond review and court control. (Lord Scarman in Gillick at p 184) Overriding control is vested in the Court as to the best interests of the child. The sovereign's right to protect children, in course of time, passed on to the Lord Chancellor and then to the Judges and formed part of the inherent jurisdiction of the High Court. See Re B (A Minor) Wardship: Medical Treatment: 1981(1) WLR 1424. (per Templeman and Dunn L JJ). Under the family law, the test for overriding the parents' refusal is the child's paramount welfare or interest (Re B (A Minor Wardship: Sterilisation: 1988 AC 199 (per Lord Hailsham of St. Marylebone LC). The meaning of welfare here is described as 'not limited to best medical interests' (Butler-Sloss LJ in Re MB (Medical Treatment

1997(2) FLR 426 (439). In Re A (Male Sterilisation) 2000 (1) FLR 55, she stated

“In my judgment, best interests encompasses medical, emotional and all other welfare issues”.

Mary’s best welfare & best interests: As Mary would instantly die, this question was crucial to the case. The first question was ‘what are the gains and losses to her from the intervention. In Re F, Lord Brandon of Oakbrook did say that “the operation or other treatment will be in her 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”. This test does not help as Mary will die immediately after the operation.

The Judge then sought aid from the principles laid down in Airedale. That was a case in which termination was granted in respect of a PVS patient. Airedale has been subjected to academic scrutiny. See:-

- (i) Kennedy & Grubb: Withdrawal of Artificial Hydration and Nutrition: Incompetent Adult: (1993) 2. Med L Rev 359;
- (ii) Kennedy & Grubb, Medical Law (2<sup>nd</sup> Ed) Ch. 16
- (iii) J. Finnis – ‘Blood, Crossing the Rubicon: (1993) 109 LQR 329
- (iv) J Keown: Restoring Moral and Intellectual Shape to the Law after Bland: (1997)113 LQR 481.

Airedale's principles on culpability were summarized into six parts as follows:

- “(i) There was some recognition that the intention was to cause death.
- (ii) Actively to bring a patient’s life to an end is: to cross the Rubicon which runs between, on the one hand, the care of the living patient and, on the other hand, euthanasia – actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law” – per Lord Goff at p. 865 F.
- (iii) Withdrawal of treatment was, however, properly to be characterized as an omission.
- (iv) An omission to act would nonetheless be culpable if there was a duty to act.
- (v) There was no duty to treat if treatment was not in the best interests of the patient.
- (vi) Since there was no prospect of the treatment improving his condition the treatment was futile and there was no interest for Tony Bland (in Airedale) in continuing the process of artificially feeding him upon which the prolongation of his life depends.”

Quality of life:

Proposition (iv) and (v) were taken up by Ward LJ in the context of Mary. Would Mary’s life, if not separated from his twin, “be worth nothing to her”? ‘Quality of life’ that would continue after surgery was treated as relevant in Re B in 1981: 1981(1) WLR 1424 where Templeman & Dunn LJJ referred to it. The former said the test to be adopted was

“... whether the life of this child is demonstrably going to be so awful that in effect the child must be condemned to die.”

After referring to the above, Ward L J quoted the case decided by him in In Re C (A Minor) (Wardship: Medical Treatment)(dt. 14.4.89) 1990 Fam 26 (on appeal see Re C: 1989(2) All ER 782, dt. 20.4.89) where he approached the question as follows: firstly that no treatment would alter the hopelessness of the child’s position and secondly, that in so far as he was able to assess the quality of life “which as a test in itself raises as many questions as it can answer”. He judged the quality of the child’s life as demonstrably “awful and intolerable”, following Re B.

Similarly in Re J (A minor)(Wardship: Medical Treatment): 1990 (3) All ER 930 (CA), the Court of Appeal rejected the Official Solicitor’s submission and stated that ‘life would be intolerable to the child judged from the perspective of the child’.

After referring to the views of academics and others and to the ‘right to life’, Ward LJ said that he would not agree that ‘Mary’s life would be worth nothing to her’. Her life had its own “eneliminable” value and dignity.

Next question is whether “To prolong Mary’s life.. would be very seriously to her disadvantage?” But as the proposed treatment would not prolong her life, this question does not arise. According to Lord Goff in

Airedale, the decision to discontinue a line of treatment which prolongs life is governed by the principle of the patient's best interests.

In the present case, the treatment amounts to an invasion and Mary's consent is necessary. Mary is not receiving treatment and there is also no question of discontinuing a treatment.

Hence, the proposed surgery is not in Mary's interests according to Ward LJ. But, this conclusion was not end of the judgment of Ward LJ. He posed further questions.

Two children – parents wishes relevant subject to welfare principle:

What does the Court do now? If the operation is in Jodie's interest and not in Mary's interest, can it be allowed? Ward LJ then referred to the provisions of the Children's Act, 1984 and to Birmingham City Council vs. H (A Minor) 1994(2) AC 212, where the mother who delivered a child was herself a 'child'. It was held that the Court must approach the question without giving priority to one child over the other. A balance has to be struck and her parents wishes become relevant. Parents' wishes are subordinate to the welfare of the child. Re KD (A minor) (Ward: Termination of access). After referring to J vs. C 1970 AC 668, Reg vs. Gynboll 1893(2) QB 232 he referred to In Re Z (A minor)(Identification: Restrictions on publication) 1997 Fam 1, where Sir Thomas Bingham MR said that here, the Court can consider the parents' wishes but give its own judgment as to what is in the child's welfare.

Court's power to review the decision of the decision maker:

The next question according to Ward LJ is whether the role of the Court is of a reviewer or a decision maker? In Re T: (Wardship: Medical treatment) 1997(1) All ER 906 (CA), the Court of Appeal went by the parents' refusal to the liver transplant of the patient: (Butler-Sloss, Waite, Rock L.J.J). Waite LJ stated in that case that the "scale, at one end of which lies the clear case where parental opposition to medical intervention is prompted by scruple or dogma of a kind which is particularly irreconcilable with principles of child health and welfare widely accepted by the generality of mankind, and that, at the other end lie highly problematic cases where there is genuine scope for a difference between the parent and the Judge. In both situations, it is the duty of the Judge to allow the Court's opinion to prevail in the perceived paramount interest of the child concerned but in cases as the latter end of the scale, there must be a likelihood (though never, of course, a certainty) that the greater the scope for genuine debate between one view and another, the stronger will be that inclination of the Court to be influenced by a reflection that in the last analysis, the best interests of every child include an expectation of difficult decisions affecting the length and quality of its life will be taken for it by the parent to whom its case has been entrusted by nature."

After thus referring to Waite LJ's observations, Ward LJ then considered two questions finally – (1) What weight is to be given to parents wishes, (2) How the balance is to be struck: Ward LJ ultimately concludes: (p 41)

“I am in no doubt at all that the scales come down heavily in Jodie’s favour. The best interests of the twins is to give the chance of life to the child whose actual bodily condition is capable of accepting the chance to her advantage even if that has to be at the cost of the sacrifice of the life which is so unnaturally supported. I am wholly satisfied that the least detrimental choice, balancing the interests of Mary against Jodie and Jodie against Mary, is to permit the operation to be performed”.

Ward LJ said that a declaration will be granted as above, provided it is lawful according to criminal law.

Then Ward LJ took up criminal law and agreed with Brooke LJ’s separate opinion in the same case as to why doctors could not be found fault with on the criminal side if the twins were separated. He went into the definition of murder, the meaning of ‘intention’, the ‘doctrine of double effect’ (the act which produces a bad effect is nevertheless morally permissible if the action is good in itself), killing, unlawfulness, doctrine of necessity, policy of the law, legal duties; offending the sanctity of life principle, and concluded (pp 41-46)

“For these reasons, very shortly expressed, I conclude that the operation which I would permit, can be lawfully carried out”

Then Ward LJ considered the Human Rights Act, 1988 (which was yet to come into force) and the judgment of the European Commission Paton vs.

United Kingdom (1980)<sup>3</sup> EHRR 408, which construed Art 2 and he stated that the action proposed complied with that Act too.

Finally Ward LJ concluded (at p 47):

“In my judgment, the appeal must be dismissed. Lest it be thought that this decision could become authority for wider propositions, such as that a doctor, once he has determined that a patient cannot survive, can kill the patient, it is important to restate the unique circumstances for which this case is authority. They are that it must be impossible to preserve the life X without bringing about the death of Y, that Y by his or her very continued existence, will inevitably bring about the death of X within a short period of time; and that X is capable of living an independent life but Y is incapable under any circumstances (including all forms of medical intervention) of viable independent existence. As I said at the beginning of the judgment, this is a very unique case”.

Brooke and Walker LJJ:

Brooke LJ wrote (pp 47 to 74) a very elaborate judgment on the doctrine of necessity in criminal law and concluded that the interests of Judic required the surgery even if M may die as a result. Robert Walker concurred (pp 74 to 88).

(19) Re T (Wardship: Medical Treatment) (CA) 1997(1) WLR 906 (Butler Sloss, Waite and Rock L JJ) (24.10.96) (This case has been referred in the Twin’s case above)

A male child who was born with a life-threatening liver defect underwent surgery soon after birth, when he was three and a half weeks old. The operation was unsuccessful and caused the child considerable pain and distress. Medical prognosis was that he would not live beyond 2 ½ years if there was no liver transplant. The doctors expressed the view that the child was suitable for liver transplant, though it was a complicated procedure, and that there were chances of success and if the liver was transplanted, the child could live for many years, a normal life. The mother refused consent as she felt the surgery would be painful. The local authority applied to the Court for permission to have surgery performed. The Judge held that the mother's opposition was unreasonable and directed surgery.

On appeal by the mother, the judgment was reversed where invasive surgery was likely to prolong life of a child born with a threatening defect and the parents opposed surgery and refused consent, the paramount consideration was no doubt for the welfare of the child and about the reasonableness of the mother's refusal. Since the child's welfare depended on the mother who is expected to take care of the child, her views were relevant and the trial Judge erred in deciding that her view was unreasonable. The Judge failed to assess the relevance or the weight of the mother's concern as to the benefits to her child on account of the surgery and post-operative treatment, the dangers of failure both long-term as well as short term treatment, the possibility of the need for further transplant, the likely length of life and the effect on her child of all those concerns together with the strong reservations expressed by one of the doctors about coercing

the mother into playing a crucial part in the aftermath of the operation and thereafter.

(20) Re A (Male Sterilisation): 2000(1)FLR 549 : (Butler-Sloss & Thorpe LJ)

Butler-Sloss LJ stated that ‘best interests’ encompass ‘medical, emotional and all other welfare issues’.

Thorpe LJ laid down the principle on the basis of which a Judge should decide the “best interests” of a patient. He said:

“There can be no doubt in my mind that the evaluation of best interests is akin to a welfare appraisal.....

Pending the enactment of a checklist or other statutory direction, it seems to me that the first-instance Judge, with the responsibility to make an evaluation of the best interests of a claimant lacking capacity, should draw up a balance sheet. The first entry should be of any factor or factors of actual benefit. In the present case, an instance would be the acquisition of foolproof contraception. Then on the other sheet, the Judge should write any counter-balancing dis-benefits to the applicant. An obvious instance in this case would be the apprehension of risk and the discomfort inherent in the operation. Then the Judge should enter on each sheet the potential gains and losses in each instance making some estimate of the extent of the possibility that the gain or loss might accrue. At the end of that exercise, the Judge should be better placed to strike a balance between the sum of the certain and possible gains against the sum of

the certain and possible losses. Obviously, only if the account is in relatively significant credit will the Judge conclude that the application is likely to advance the best interests of the claimant.”

- 21) Ms. B vs. An NHS Hospital Trust: 2002 EWHC 429. (Dame Elizabeth Butler Sloss (President of the Family Court) (d. 22.3.2002)

Ms B, born in 1956, was a post-graduate and she was a teacher in Social Work, and had a Management Diploma. On 26.8.99, she suffered haemorrhage of the spinal column in her neck. Cavernoma was diagnosed, being a malformation of blood vessels in the spinal cord. She executed a living will on 4.9.99, which instructed that if she suffered from life threatening condition or permanent mental impairment, the treatment be withdrawn. She recovered from treatment, worked in her job, but in 2001, she suffered weakness. She suffered cervical spine cavernoma as a result of which she became tetraplegic, suffered complete paralysis from neck down. She was put in ICU on 16.2.2001. She had to be put on ventilator. She recovered and again her health failed, put in ICU on 28.3.2001, but this time she asked that the ventilator be withdrawn. Psychiatrists were divided in their view of her capacity. She recovered and made a further living will on 15.8.2001 and refused treatment till November. She moved the Court for declaration that the treatment was invasive and was a trespass.

Butler-Sloss J referred to the principle of ‘autonomy’. That principle accepts the capacity of a person of full age to consent or not to consent to medical treatment. It was laid down by Lord Reid in S vs. McC: W vs W: 1972(AC) 25(43 and by Lord Goff in Re F (Mental Patient:

Sterilisation) 1990(2) AC1 and by Lord Donaldson in re T. 1992(4) All ER 649. She referred to the observations of Robins JA in Malette vs. Shulman 67 DLR (4<sup>th</sup>) 321 (336), Re MB (Medical Treatment) 1997(2) FLR 426 and stated that the approach is identical with the jurisprudence in other parts of the world. In Cruzan vs Director (1990) 497 US 261, the US Supreme Court stated “No right is held more sacred, or is more carefully guarded.... than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law”.

The principle of sanctity of life (i.e. protecting or prolonging life) is also accepted to be not absolute but that it is still a concern of the State, including the judiciary. At the same time, no medical officer can be compelled to treat a patient against his wishes, even if death is imminent. This principle of sanctity of life was explained by Lord Keith in Airedale 1993 AC 789 (859) and Lord Goff (p 864). See also Nancy B vs. Hotel – Dieu de Quebec : (1992) 86 DLR (4<sup>th</sup>) 385) where in a case before the Quebec Supreme Court, a 25 year old woman with an incurable neurological disorder refused ventilation and the Court accepted her prayer to stop ventilation.

As to mental capacity, there is a presumption that every person possesses mental capacity to decide about medical treatment but this can be rebutted (Re MB : 1997(2) FLR 426 (436). Assessing capacity is a difficult exercise. As stated by Justice Steffen in McKay vs. Bugstedt (1990) 801 P. ed 617 (Nev Sup ct) 2(at p 5), in regard to Kenneth who was 31 years and tetraplegic from the age of 10:

“One of the verities of human experience is that all life will eventually end in death. As the seasons of life progress through spring, summer and fall, to the winter of our years, the expression unknown to youth is often heard evincing the wish to one might pass away in the midst of a peaceful sleep. It would appear, however, that as the scientific community continues to increase human longevity and promote ‘the greying of America’, prospects for slipping away during peaceful slumber are decreasing. And for significant number of citizens, like Kenneth, misfortune may rob life of much of its quality long before the onset of winter.”

In that case Kenneth pleaded for his release from a life of paralysis held intact by the ‘life sustaining properties of a respirator’.

Judge Dame Butler-Sloss then quoted from Bartling vs. Superior Court of Los Angeles County (1984) 163 Cal App(3d) 186, where it was held that the patient’s previous ambivalence about withdrawal of treatment was not relevant to the assessment of his capacity:

“The fact that (a patient) periodically wavered from this posture (i.e preferring death to his intolerable life on the ventilator) because of severe depression or for any other reason, does not justify the conclusion of (the hospital) and his treating physicians that his capacity to make such a decision was impaired to the point of legal incapacity. (Lane vs. Candura: (1997) NE (2d), 1232, 1234).”

She also referred to a similar ambivalence in the case before her, the medical evidence of number of doctors, and concluded that Ms B was

competent to make all relevant decisions about her treatment including the decision about withdrawal of artificial ventilation and granted her prayer for withdrawal, after distinguishing St Geroge's Health Care NHS Trust Vs J (1999) Fam 20(63). She gave 10 guidelines on mental capacity:

“Guidance has already been given by the Court of Appeal in St. George's Healthcare NHS Trust V. S (1999) Fam 26 at page 63 in the Guidelines at page 758 et seq. The circumstances of the present case are however very different from the facts of that case. It might therefore be helpful if I restate some basic principles and offer additional guidelines in case a situation similar to the present should arise again.

- i) There is a presumption that a patient has the mental capacity to make decisions whether to consent to or refuse medical or surgical treatment offered to him/her.
- ii) If mental capacity is not in issue and the patient, having been given the relevant information and offered the available options, chooses to refuse the treatment, that decision has to be respected by the doctors. Considerations that the best interests of the patient would indicate that the decision should be to consent to treatment are irrelevant.
- iii) If there is concern or doubt about the mental capacity of the patient, that doubt should be resolved as soon as possible, by doctors within the hospital or NHS Trust or by other normal medical procedures.

- iv) In the meantime, while the question of capacity is being resolved, the patient must, of course, be cared for in accordance with the judgment of the doctors as to the patient's best interests.
  
- v) If there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision.
  
- vi) In the rare case where disagreement still exists about competence, it is of the utmost importance that the patient is fully informed of the steps being taken and made a part of the process. If the option of enlisting independent outside expertise is being considered, the doctor should discuss this with the patient so that any referral to a doctor outside the hospital would be, if possible, on a joint basis with the aim of helping both sides to resolve the disagreement. It may be crucial to the prospects of a good outcome that the patient is

involved before the referral is made and feels equally engaged in the process.

- vii) If the hospital is faced with a dilemma which the doctors do not know how to resolve, it must be recognized and further steps taken as a matter of priority. Those in charge must not allow a situation of deadlock or drift to occur.
- viii) If there is no disagreement about competence but the doctors are for any reason unable to carry out the wishes of the patient, their duty is to find other doctors who will do so.
- ix) If all appropriate steps to seek independent assistance from medical experts outside the hospital have failed, the NHS Hospital Trust should not hesitate to make an application to the High Court or seek the advice of the Official Solicitor.
- x) The treating clinicians and the hospital should always have in mind that a seriously physically disabled patient who is mentally competent has the same right to personal autonomy and to make decisions as any other person with mental capacity.

All those reading this judgment must be careful to recognize the importance of complying with the publicity injunction set out at the beginning of this judgment.”

- 22) Simms Vs An NHS Trust 2002 EW HC 2734 (Dame Elizabeth Butler Sloss, President) (11.12.2002)

This case related to two patients from different families, where the patients, a boy of 18 and a girl of 16 each were suffering from a variant of Creutzfeldt – Jakob disease. Both sets of parents wanted a particular treatment, so far untested on human beings, be given as the patients did not have the mental capacity to think. The patients were lying in bed totally invalid.

The Judge quoted from her judgment In Re A: (Male Sterilisation) 2001(1) FLR 549 (555) as follows:

“The doctor, acting to that required standard, has, in my view, a second duty, that is to say, he must act in the best interests of a mentally incapacitated patient: (See also “Re S (Adult Patient Sterilisation)” 2001 Fam 12.”

She also referred to Lord Goff in Re F (Mental Patient: Sterilisation) 1990 (2) AC 1 (77) that the doctor, and others have

“to exercise a choice in exactly the same way as would the Court or reasonable parent in relation to a child, making due allowance, of course, for the fact that the patient is not a child, and I am satisfied that is what the law does in fact require.”

Best interests are not necessarily medical, they include emotional and all other welfare issues: (Re MB – 1997(2) FLR 426).

The learned Judge then posed the question whether the high doses of PPS have the support of a responsible body of medical opinion in UK. After referring to Bolam test, and Sidaway (1985) AC 871 (893), that there was a view in favour of the treatment, if any, suggested by a responsible

body of professionals. She analysed the risks and benefits and the best interests. After holding that it was in their best interest and there was no alternative treatment available and that the parents wanted it and the pain of the surgery was to be short-lived, she permitted the PPS treatment be given and held that it was lawful to do so.

23) Re SG (Adult mental patient: Abortion : 1991(2) FLR 329 (Sir Stephen Brown).

This was case of a pregnant, severely mentally handicapped 26 year old lady. A termination had been recommended by her GP and a consultant gynaecologist. In the light of the House of Lord's decision in Re F, her father sought a ruling as to whether a formal declaration of the Court was required before a termination of pregnancy was performed. The Abortion Act 1967 permitted termination if there was certificate by two medical practitioners to the effect (a) that the continuance of pregnancy would involve risk to the woman's life or injury to her physical or mental health or to that of any existing children, outweighing the risks of terminating pregnancy; or (b) that there is a substantial risk that the child if born would suffer from a physical or mental abnormality such as to be seriously handicapped.

The question is whether, in the case of mentally incapacitated woman, the declaration of the Court was necessary.

Stephen Brown P held that the termination of a pregnancy was already closely regulated by the Act which provided 'fully, adequate safeguards for doctors who are to undertake this treatment' (at p 331). He

held that it was not necessary to seek the special approval of the High Court before the termination of a pregnancy, provided the three conditions in sec 1 of the Abortion Act were complied with. (Stephen Brown J had said the same thing in Re GF (medical treatment) 1992(1) FLR 293) He, however, said that this was a developing branch of law and that the Law Commission or the Medical Ethics Committee of the British Medical Association could go into the matter.

(24) Re S (Adult Patient: Sterilisation): 2001 Fam 15 (CA).

In this case, Dame Elizabeth Butler Sloss said that the criteria accepted by Stephen Brown in Re GF (1992)(1) FLR 293 ought to be cautiously interpreted and applied. In a separate judgment, Thorpe LJ said that, if there was a case near the boundary line, the parties could approach the Court.

(25) Re SS (an adult: Medical Treatment) 2002(1) FLR 73: (Wall J)

This case again related to termination of pregnancy. The patient was being treated in the psychiatric hospital.

Wall J held that problems with pregnant patients in psychiatric hospital are not unusual. The issue of the termination of pregnancies in such circumstances must arise frequently. He stated that it is essential that each hospital should have a protocol to deal with possible termination of such pregnancies, and that the protocol should be designed to address the issue in good time so that, wherever practicable, and in the interests of the patient, a termination can be carried out at the earliest opportunity. Furthermore, any such protocol should ensure that the patient is referred, at an early stage, to obtain independent legal advice, whether from the Official

Solicitor or the solicitor who, as in this case, appears to have represented her at the Mental Health Review Tribunal.

(26) Re S (Hospital Patient: Court's Jurisdiction) (1996 Jan 1).

In this case, Sir Thomas Bingham MR said (p 18):

“In cases of controversy and cases involving momentous and irrevocable decisions, the Courts have treated as justiciable any genuine question as to what the best interests of a patient require or justify. In making these decisions, the courts have recognized the desirability of informing those involved whether a proposed course of conduct will render them criminally or civilly liable, they have acknowledged their duty to act as a safeguard against malpractice, abuse and unjustified action; and they have recognized the desirability, in the last resort, of decisions being made by an impartial, independent tribunal.”

(27) NHS Trust vs D: 2003 EWHC 2793 (Coleridge J) (pregnancy case)

The defendant was a young adult lady suffering from severe schizophrenia. She was 18 and became pregnant. She was not capable of making a decision. Her doctors advised termination of pregnancy. An application by the claimant-hospital was allowed permitting termination as the procedure under the Abortion Act, 1967, namely, certificates of two doctors were there and conditions mentioned in Sec 1 of that Act were satisfied. Declaration was granted. (2002 EWHC (Fam) 3184 referred)

It was stated that, however, after the coming into force of Human Rights Act, 1998, questions arose as to whether Sec 1 of the Abortion Act,

1967 could be applied to mentally incompetent patients, or whether other procedures were necessary.

Coleridge J referred to the decision of Sir Stephen Brown P in Re SG (adult mental patient: abortion) : 1991 (2) FLR 329 (already referred to) and stated that procedures under Abortion Act, 1967 of obtaining opinion of two doctors is sufficient even in the case of a pregnant woman who is not having mental capacity. He referred to the caution that has to be taken while accepting the judgment of the doctors, as stated by the Court of Appeal in Re S (adult patient: sterilization) (2001 Fam 15)(CA), and clarified the position between normal cases arising under that Act where the woman has capacity to take a decision and other cases where the woman is not competent. Coleridge J stated as follows:

“The safeguards provided by the Abortion Act 1967 provide comprehensive and adequate protection for competent adults who have made their own decision to terminate a pregnancy. A mentally incapacitated woman, however, does not have the opportunity to weigh all the factors and make a decision for herself. If the guidance in Re SG were to be strictly applied, it would leave responsibility for all such decisions for mentally incapacitated women, regardless of circumstances, with their medical professionals. This cannot be correct in all circumstances.

The advent of the Human Rights Act, 1998 has enhanced the responsibility of the Court to protect positively the welfare of these patients, and in particular to protect the patient’s right to respect for her private and family life under Art 8(1) of the European Convention on Human Rights.”

Even so, in pregnancy cases, “where the issues of capacity and best interests are clear and beyond doubt, an application to the Court is not necessary.”

But, “where there is any doubt as to either capacity or best interests, an application to the Court should be made. In particular and without limiting the generality of that proposition, the following circumstances would ordinarily warrant the making of an application:

- (i) where there is a dispute as to capacity, or where there is a realistic prospect that the patient will regain capacity, following a response to treatment, within the period of her pregnancy or shortly thereafter;
- (ii) where there is a lack of unanimity amongst the medical professionals as to the best interests of the patient;
- (iii) where the procedures under Sec 1 of the Abortion Act, 1967 have not been followed (i.e. where two medical practitioners have not provided a certificate);
- (iv) where the patient, members of her immediate family or the foetus’ father have opposed or expressed views inconsistent with a termination of the pregnancy; or
- (v) where there are other exceptional circumstances (including where the termination may be the patient’s last chance to bear a child)”

Even if a case is filed anywhere near the boundary line of any one of the above criteria, it should be referred to the Court, to avoid doubts, as stated by Thorpe LJ in Re S (adult patient sterilisation) 2001 Fam 15. Further, as stated by Wall J in Re SS: 2002 (1) FCR 73, the importance of

making necessary applications in good time cannot be overstated. It is imperative that the medical profession ensures that adequate protocols are put in place for the timely resolution of these issues.

28) An NHS Hospital Trust v. S & others: (2003) EWHC 365 (Fam)  
(Dame Elizabeth Butler-Sloss P) (6<sup>th</sup> March 2003):

S, aged 18, was born with a genetic condition, velo-cardiac facial syndrome, and was suffering from ‘global development delay’ and ‘bilateral renal dysplasia’. He has been under haemo-dialysis since May 2000. He has severe learning disability with problems arising from limited understanding of medical treatment he is receiving. He is diagnosed as autistic. He suffers from epilepsy, a tendency to blood-clotting and has a moderate immuno-deficiency. His mental capacity has been assessed as that of a 5 or 6 year child. He clearly does not have the capacity to take decisions about his medical treatment.

The Hospital approached the Court seeking a declaration that the Hospital need not perform kidney-transplantations since that would not be in S’s best interests and that S should not undergo peritoneal dialysis. Only haemo-dialysis could continue for the foreseeable future and if it no longer be provided, no other form of dialysis should be given except palliative care. The parents opposed the plea of the Hospital and wanted the kidney transplantation to go on. His mother offered to donate a kidney. The Official Solicitor, representing S, wanted all forms of dialysis should be considered and he reserved his views on suitability of kidney transplantation.

However, later, it was agreed by all that haemodialysis be given and if it could no longer be given, then peritoneal dialysis be given and that transplantation of kidney was not in his best interests. There still remained two areas of disagreement:

- (1) There was a difference of opinion as to whether or in what circumstances a kidney transplantation would ever be suitable for S.
- (2) There was strong disagreement over the possibility of giving S a different form of haemodialysis by the use of AV fistula.

After analyzing the medical evidence, and the legal principles as

(1) to ‘best interests: sanctity of life’ as stated in Re B (A minor: Wardship: Medical Treatment) 1981 (1) WLR 1421 (CA) and by Lord Goff in Airedale 1993 AC 789,

(2) duty of medical profession, as stated by Lord Goff in Re F (mental patient: sterilisation) 1990 (2) AC 1; Simms v. Simms and PA vs. JA: 2002 (EWHC 2734),

(3) ‘best interests: duty of Court’: as explained in Re A (Male Sterilisation) 2000 (1) FLR 549)

the Court proceeded to decide the issues.

Butler-Sloss P referred to what Thorpe LJ said in Re A (Male Sterilisation) 2000(1) FLR 549 (at p.560) as follows:

“There can be no doubt in my mind that the evaluation of best interests is akin to a welfare appraisal.....

Pending the enactment of a checklist or other statutory direction, it seems to me that the first-instance Judge, with the responsibility to make an evaluation of the best interests of a claimant lacking capacity, should draw up a balance-sheet. The first entry should be of any factor or factors of actual benefit. In the present case, an instance would be the acquisition of foolproof contraception. Then on the other sheet, the Judge should write any counter-balancing dis-benefits to the applicant. An obvious instance in this case would be the apprehension of risk and the discomfort inherent in the operation. Then the Judge should enter on each sheet the potential gains and losses in each instance making some estimate of the extent of the possibility that the gain or loss might accrue. At the end of that exercise, the Judge should be better placed to strike a balance between the sum of the certain and possible gains against the sum of the certain and possible losses. Obviously, only if the account is in relatively significant credit will the Judge conclude that the application is likely to advance the best interests of the claimant.”

Butler-Sloss P said she would add ‘his enjoyment of life’ as an additional factor to be weighed. After considering S’s ability to cope with the treatment, the four options for treatment, namely, Haemodialysis via central catheter, peritoneal dialysis AV fistula in the arm and possible

kidney transplantation in the future - (under separate headings) -, the learned Judge observed:

- “(1) S cannot make his own decisions as to his future medical care since he does not have capacity to do so;
- (2) I am satisfied that it is in his best interests to continue his present haemodialysis treatment;
- (3) I consider that the possibility of an AV fistula should not be excluded after he has settled into the adult way of life;
- (4) When haemodialysis is considered by the medical team caring for him (as) no longer to be effective, I agree with the medical evidence that he should move to peritoneal dialysis;
- (5) The possibility of a kidney transplantation should not be excluded on non-medical grounds.”

29) HE v. Hospital NHS Trust & Anor: (2003) EWHC 1017 (Justice Munby) (7<sup>th</sup> May 2003)

This case is important and deals with the validity of “Advance Directives”. While Munby J was sitting in urgent applications, the father of the patient made an application in the afternoon on a Friday (2<sup>nd</sup> May 2003) for relief to save the life of his daughter. It was obvious that speed was of the essence. The Official Solicitor acted fast and came to Court at short notice. The Court made the order permitting blood transfusion in spite of the Advance Directive and Munby J gave reasons five days later.

In this case, the claimant, the father (HE) and his family were Muslims, and the 2<sup>nd</sup> defendant (AE) was his daughter, aged 24 years, was born and brought up as a Muslim. But when her parents separated, she and her brother went to live with their mother. The mother became a Jehovah's Witness and her children followed suit. AE was then brought up as a Jehovah's Witness. AE suffered from congenital heart problem, which required surgery when she was a child and she knew that further surgery would be necessary when she became an adult. On 13<sup>th</sup> February 2001, she signed a printed Advance Medical Directive/Release and her signatures being witnessed by two Ministers of her Church, excluding, among others, blood transfusion. In November 2002, the doctors felt that as she was a Jehovah's witness, she could be given surgery using erythropoietin to stimulate blood production but on 20<sup>th</sup> November 2003, AE became ill suddenly, and the doctors felt that surgery was necessary and some partial amputation was also necessary on her hands, which was not possible without blood transfusion. Her mother and brother objected in spite of being told that there was risk of death to AE.

AE was sedated from 20<sup>th</sup> April 2003 till 2<sup>nd</sup> May, when the father moved the present application, as her position became extremely critical. The father stated in writing giving seven reasons why the Advance Directive of AE should not be acted upon.

Justice Munby heard the case at 2.20 PM on 2<sup>nd</sup> May 2003 and he read the statement of the father and the doctor's faxed statement. The Official Solicitor agreed to act as her litigation-friend as AE was not conscious. The Judge consulted Kennedy and Grubb; Principles of Medical

Law (Ed 1998) (paras 3009 and 4.105 - 4.114) and referred to Re T (Adult: Refusal of Treatment) 1993 Fam 95 and Re AK (Medical Treatment: Consent) 2001 (1) FLR 129 and soon thereafter granted a declaration that it would be lawful to give blood transfusion in spite of the Advance Directive.

On 7<sup>th</sup> May 2003, the Judge gave reasons. These are quite important.

Munby J started saying that three propositions are now well-settled and it is not necessary to cite authority:

- (1) A competent adult patient has an absolute right to refuse consent to any medical treatment or invasive procedure, whether the reasons are rational, irrational, unknown or non-existent, and even if the result of refusal is the certainty of death. He agreed with Prof. Andrew Grubb's observation (see 2002 Med L Rev 201 at 203) that: 'English law could not be clearer. A competent adult patient once properly informed, has the unassailable right to refuse any or all medical treatment or care'.
- (2) Consistently with this, a competent adult patient's anticipatory refusal of consent (a so-called advance-directive or a living-will) remains binding and effective notwithstanding that the patient has subsequently become and remained incompetent.
- (3) An adult is presumed to have capacity, so the burden of proof is on those who seek to rebut the presumption and who assert a lack of capacity."

The learned Judge further referred to burden of proof as follows:

As to the law on burden and standard of proof, he held:

- (i) While there is a presumption in favour of capacity and the burden to prove incapacity is on those who dispute capacity, there is another burden where there is an advance directive. This burden is on those who rely on the advance directive to prove its existence, its continuing validity and applicability. If there is doubt, that doubt falls to be resolved in favour of preservation of life.
- (ii) As to standard of proof of the advance directive, it must be clear and convincing based on balance of probabilities as in civil cases. The more extreme the gravity of the matter in issue, the stronger and more cogent the evidence must be. When life is at stake evidence must be scrutinized with special care. (In re H. (Minors) (Sexual Abuse: Standard of Proof) 1996 AC 563 and dictum of Ungood – Thomas J in Re Dellow's Will Trusts: 1964 (1) WLR 451 (455). The continuing validity and applicability of the advance directive must be established by clear convincing and inherently reliable evidence.
- (iii) Depending upon the lapse of time and the known changes in the patient's circumstances during that time, the validity of the advance directive has to be examined. See In re T: (Adult: Refusal of Treatment) 1993 Fam 95, Lord Donaldson MR (p 103) where he referred to two 'ys' for the validity of an advance directive or anticipatory choice. He said that there is:

“... a conflict between two interests, that of the patient and that of the society in which he lives. The patient’s interest consists of his right to self-determination – his right to live his own life, how he wishes, even if it will damage his health or lead to his premature death. Society’s interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible. It is well-established that in the ultimate, the right of the individual is paramount. But this merely shifts the problem where the conflict occurs and calls for a very careful examination of whether, and if so the way in which, the individual is exercising that right. In case of doubt, that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, he must do so in clear terms”.

Munby J refers to Lord Donaldson’s statement (at p 114) that an ‘advance directive’ ‘may have been based upon an assumption’, in which case, it is necessary to examine the assumption. Lord Donaldson said:

“If... the assumption upon which it is based is falsified, the refusal ceases to be effective. The doctors are then faced with a situation in which the patient has made no decision and he by then being unable to decide for himself, they have both the right and the duty to treat him in accordance with what in the exercise of their clinical judgment they consider to be in his best interests.”

Munby J refers to Francis & Johnston, ‘Medical treatment: Decisions and the Law’ (Ed 2001) (para 1.29) that a patient’s consent to treatment will not survive a material change of circumstances. In the same way, says Munby J that, a patient’s anticipatory refusal to treatment will not survive a material

change of circumstances. He quotes Lord Goff in Airedale (at p 864) where it is stated that an advance directive must be considered with ‘especial care’. “.... Especial care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred.”

Munby J also refers to what Hughes J said in Re AK: 2001(1) FLR 129 (p 134):

“... in the case of an adult patient of full capacity, his refusal to consent to treatment or care must in law be observed. It is clear that in an emergency, a doctor is entitled in law to treat by invasive means, if necessary, a patient who, by reason of the emergency, is unable to consent, on the ground that the consent can, in those circumstances, be assumed. It is, however, also clearly the law that the doctors are not entitled so to act if it is known that the patient, provided he was of sound mind and full capacity, has let it be known that he does not consent and that such treatment is against his wishes. To this extent an advance indication of the wishes of a patient of full capacity and sound mind are effective. Care will of course have to be taken to ensure that such anticipatory declarations of wishes still represent the wishes of the patient. Care must be taken to investigate how long ago the expression of wishes was made. Care must be taken to investigate with what knowledge the expression of wishes was made. All the circumstances in which the expression of wishes was given will, of course, have to be investigated.”

This is so far as burden of proof and standard of proof of advance directives and their continued validity and applicability.

On the validity of the advance directive, Munby J said – there are no legal requirements of forms. In fact, it need not even be in writing (In Re T). It may be oral or in writing. It should be a firm and settled view of the person and not an offhand remark or casual expression. The same principle applies to a ‘revocation of an advance directive’. The popular term ‘a living will’ is misleading. It is not governed by the (UK) Wills Act, 1837. A written advance directive can be revoked even orally. An irrevocable advance directive is a ‘contradiction in terms’. It is a legal impossibility. Munby J stated:

“A free man can no more sign away his life by executing an irrevocable advance directive refusing life-saving treatment than he can sign away his liberty by subjecting himself to slavery. Any condition in an advance directive purporting to make it irrevocable is contrary to public policy and void.”

Yet another proposition laid down by Munby J was that if there was an advance directive, none except the person who made it can revoke it and it remains effective if the person has later become incompetent due to his health condition. But, he cannot impose formal or other conditions upon its revocation and they would be void as being contrary to public policy. Hence, paragraph (2d) of the Advance Directive which reads as:

“that the Advance Directive shall remain in force and bind all those treating me unless and until I expressly revoke it in writing”

is void as being contrary to public policy. Revocation in writing is not necessary. It can be oral. The patient could orally say she has renounced her faith as a Jehovah's witness. It will also be invalid if it had stated that it had to be revoked in the presence of two witnesses.

In the present case, AE seems to have been influenced by a wish to return to her original faith (Muslim religion) in order to marry a Muslim. A 'secular system of law founded on the freedom of the individual cannot hold bound to his previous written statement, a patient whose courage fails him as he is wheeled into the operation theatre, whatever he may previously have said in writing'. Any self-imposed factor on a patient's ability to revoke such a document will be contrary to public policy and void. The question is

“whether an advance directive has been revoked or has, for some other reason, ceased to be operative...”

This then becomes a question of fact. On that question, the burden of proof lies in those who assert the continuing validity and applicability of the advance directive.

The patient's change of mind can be evidenced by written or spoken words or may be clear from the patient's actions – for sometimes actions speak louder than words. It may be some change in circumstances. It may be alleged that the patient no longer professes the faith which underlay the advance directive; or that he has since been cured; it may be said that medical science has moved on; it may be said that since then, the patient had married and has children, and now finding himself with more compelling reasons to choose to live even in a severely disadvantaged life. It may be

suggested that the advance directive has been revoked expressly or by conduct inconsistent with the continued validity of the advance directive. Once there is some real reason for doubt, then the burden shifts to those who assert on its continuing validity and applicability. If the doubt is not removed, it gets resolved in favour of the preservation of life. If there is doubt, the advance directive cannot come in the way of the doctor deciding upon what is in the best interests of the patient. Whether such a doubt has come into play depends on the circumstances. Too skeptical a reaction to well-founded suggestions that circumstances have changed, may turn an advance directive into a death warrant for a patient who in truth wants to be treated. Munby J then stated:

“the longer the time which has elapsed since an advance directive was made, and the greater the apparent changes in the patient’s circumstances since then, as I have seen, there will need to be especially close, rigorous and anxious scrutiny”

Munby J finally summarised the law regarding ‘advance directives’ into seven propositions:

- “(i) There are no formal requirements for a valid advance directive. An advance directive need not be either in or evidenced by writing. An advance directive may be oral or in writing.
- (ii) There are no formal requirements for the revocation of an advance directive. An advance directive, whether oral or in writing, may be revoked either orally or in writing. A written advance

directive or an advance directive executed under seal, can be revoked orally.

- (iii) An advance directive is inherently revocable. Any condition in an advance directive purporting to make it irrevocable; any even self-imposed fetter on a patient's ability to revoke an advance directive, and any provision in an advance directive purporting to impose formal or other condition upon its revocation, is contrary to public policy and void. So, a stipulation in an advance directive, even if in writing, that it shall be binding unless and until revoked in writing is void as being contrary to public policy.
- (iv) The existence and continuing validity and applicability of an advance directive is a question of fact. Whether an advance directive has been revoked or has for some other reason ceased to be operative is a question of fact.
- (v) The burden of proof is on those who seek to establish the existence and continuing validity and applicability of an advance directive.
- (vi) Where life is at stake, the evidence must be scrutinized with special care. Clear and convincing proof is required. The continuing validity and applicability of the advance directive must be clearly established by convincing and inherently reliable evidence.
- (vii) If there is doubt, that doubt falls to be resolved in favour of the preservation of life.”

After laying down the above principles, Munby J relied on the father's statement before Court dated 2<sup>nd</sup> May 2003 wherein the father set

out seven reasons as to why the Advance Directive ceased to be operative: (i) that since Dec. 2002, his daughter AE rejected her faith as Jehovah's witness and desired to revert back to becoming a Muslim as a condition of her marriage to a Turkish gentleman. (ii) she stopped attending meeting/congregation or services of Jehovah's witnesses, which she used to frequently attend twice a week. She had promised her fiancé that she would not attend these meetings she has not done so from the beginning of Jan. 2003. (iii) the consent forms signed by her predated her change of faith and as such should not be relied upon. (iv) she was admitted in the hospital prior to her collapse but made no mention of the Advance Directive to the medical authorities. (v) she remained in hospital for 2 days before she was discharged and throughout that time, she did not make any reference to the Advance Directive. (vi) after re-admission into the hospital, she confirmed to her brother and aunt, that 'she did not want to die'. (vii) approximately 2 months ago, she informed her family she intended to marry her fiancé and would not allow anything to get in her way and confirmed she would follow Muslim faith.

Relying on these facts, the learned Judge held that the Advance Directive was based solely on the then religious faith of AE as a Jehovah's witness and once that faith ceased to influence her and she turned back to her original Muslim faith, the basis of the Advance Directive stood knocked down. It ceased to be 'effective' as stated by Donaldson MR in In re T. Even otherwise, there is doubt as to whether the Advance Directive continued to be valid and those doubts must be resolved in favour of preservation of life. The best interests of AE also required blood transfusion be given.

Finally, the learned Judge observed that where the facts come to the knowledge of the hospital authorities which require urgent medical intervention in respect of a patient, the hospital authorities and doctors could take expeditious action in the Court, rather than leave to one of the relatives of the patient to move the Court. (quoting Lord Donaldson in In re T (p.115).

30) NHS Trust v. T: 2004 EWHC 1279:  
(Justice Charles) (28<sup>th</sup> May 2004)

The hospital sought a declaratory relief in regard to Ms. T aged 37 years, who has borderline ‘personality disorder’. She used to harm herself by cutting herself and blood-letting, resulting in fall of haemoglobin level and leading to chronic anemia. She frequently required blood transfusion supplemented by iron. She had taken such treatment for years. But on 28.1.2004, she executed an Advance Directive, (attested by a lawyer), giving various directions refusing blood transfusion ‘unless when she is subject to compulsory treatment under the Mental Health Act, 1983’. The reasons given by her were that she was not aware when she would cut herself and she felt blood was evil and the blood given to her mixes with hers and becomes evil and that would increase the danger of her committing acts of evil again. She stated she was mentally competent while writing the Advance Directive and she named her mental health lawyer, H and another social worker be told if she was admitted in hospital. If she lacked capacity, her lawyer should be consulted and he would speak for her in a crisis.

On 24.3.2004, the treating psychiatrist opined that she was unstable and that blood transfusion and iron were necessary. On 8.4.2004, the patient reached a collapsing state. On 9.4.2004, on the application of the hospital, Pauffley J, by her order, permitted blood transfusion, using minimum force. It was given and she recovered by 13.4.2004. On 16.4.2004, her solicitor wrote objecting to further blood transfusion.

After holding that under the new C.P.R. (Civil Procedure Rules), interim declarations can be given and referring to circumstances in which, in a given case, a declaration may be too premature having regard to the capacity of the patient at the moment or the lack of emergency, Charles J held that, on the medical evidence before him, the lady Ms. T lacked capacity when she signed the Advance Directive, that as in Re MB she was unable to weigh the relevant information and competing factors. Her position, at the present moment when she again refused, was no different.

Charles J then examined what was in her best interests. He quoted Munby J in A v. A. Health Authority 2002 (1) FLR 481 that an adult's best interests involve a welfare appraisal in the widest sense of taking into account, where appropriate, a wide range of ethical, social, moral, emotional and welfare considerations. Reference was made to similar views of the President Butler-Sloss LJ in Re A (medical treatment: male sterilization) 2000 (1) FLR 549. He then quoted Thorpe LJ from Re A as to what is in best interests in the case of mental patients. The two reasons given by the patient in her advance directive that blood transfusion became a vicious circle and her blood was evil, could not be given weight. The 'potential

gains' in the balance sheet were more than the losses, as enumerated by Thorpe LJ.

- 31) Doncaster & Basset Law Hospitals NHS Trust & Anor v. C: (2004)  
EWHC 1657  
(Sumner J) (12<sup>th</sup> July 2004)

This was an application by the NHS Trust in respect of an elderly lady C, for administering general anaesthetic to C against her wishes for purpose of an LT scan. This was necessary as a prior ultrasound scan revealed a suspected renal carcinoma. The Official Solicitor did not oppose the application.

C had a history of mental illness for 40 years also. She was in hospital number of times, she was reluctant for medication, had delusional beliefs. She considered that the ultrasound report was someone else's. Medical interventions, according to her, were a plot on her. Doctors considered this as mental illness, schizophrenia etc. She was unable to weigh up the benefits and risks of treatment options.

The Judge, after referring to the objections of her counsel placed reliance on para 4(b) of the principles stated by Butler-Sloss LJ (as she then was) in Re: MB 1997 (2) FCR that inability of the patient to make a decision could be inferred "if the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision". A compulsive disorder or phobia, as stated by Thorpe J in Re: C 1994 (2) FCR 151 from which the patient suffers, stifles belief in the

information presented to her and then the decision may not be a true one. It was, therefore, in her interests to administer anaesthetic for a CT scan.

(32) R (Burke) v. The General Medical Council : (2004 EWHC 1879 (Admin))

(Munby J) (30<sup>th</sup> July, 2004) : (reversed on certain points by Court of Appeal)

This judgment, running into 224 paras (in 95 pages), reviews the entire law on the subject. That part of the judgment which strikes down some of the guidelines given by the General Medical Council of England as being contrary to several Articles of the European Convention has since been set aside by the Court of Appeal.

The learned Judge has given an index of the headings, in the opening part of the judgment, for convenience. Of importance are the following headings:

1. GMC Guidance (paras 7 to 17)
2. Artificial Nutrition and hydration (paras 18 to 20)
3. Competence, Incompetence and Advance directives (paras 41 to 50)
4. Ethical Basis of Law ( (paras 51 to 53)
5. Autonomy and Self-determination (54 to 56)
6. Dignity (para 57, 58)
7. Autonomy, dignity and (European) Convention (paras 59 to 72)

8. Tension between these principles (paras 73 to 79)
9. Conclusions (para 80)
10. Common Law (para 81)
11. Duty to Care (paras 82 to 87)
12. Best interests (paras 88 to 97)
13. Best interests and prolonging treatment (paras 98 to 113)
14. The evaluation of best interests (para 114, 115)
15. Conclusions (para 116)
16. The (European) Convention (paras 117, 118)
17. Negative and Positive obligations (paras 119 to 121)
18. (a) Inter-relationship between Arts 2, 3, 8 (paras 122 to 129) (of the Convention)  
(b) Art 8 (para 130)  
(c) Art 3 (paras 131 to 151)  
(d) Art 2 (paras 152 to 162)
19. Convention and Withdrawal of ANH (Artificial Nutrition and Hydration) (para 163 to 177)
20. Conclusions (paras 178, 179)
21. Compelling the doctor (paras 180 to 184)
22. Involving the Court (paras 195 to 211)
23. Summary and discussion (para 212)
24. Summary of Conclusions (para 213 to 214)
25. Discussion (paras 215 to 223)
26. Relief (paras 224, 225)

(Appendix: GMC Guidance) (items 9 to 82).”

The case deals with Mr. Burke, aged 44 years, who suffered from cerebellar ataxia, (a congenital brain disorder), but was mentally sound. Food was sometimes given by artificial means (artificial nutrition and hydration : ANH).

It was the patient who sought clarification from the Court for the purpose of continuing the ANH and wanted guidance as to the exceptional circumstances under which ANH could be withdrawn. He contended that certain paras (namely paras 32, 38, 81 and 82) (as also para 13, 16, 42) of the Guidance issued by the General Medical Council of England (2002) (GMC) with regard to withholding or withdrawing Life Prolonging Treatments – are inconsistent with Arts 2, 3 and 8 of the European Convention. He referred to judicial review under the Human Rights Act, 1998 (which came into force from 2.10.2000). The guidance was issued by the GMC under sec 35 of the Medical Act, 1983.

The case essentially related to patients who were not in permanent vegetative state (PVS) but the Court incidentally considered the cases of PVS patients also. Here the patient did not want the doctors to take a decision for withdrawal of life support on the assumption that his life was no longer worth living. The Official Solicitor and the Disability Rights Commission (DRC), the British Medical Council and the Ethics Committee of the British Medical Association were heard.

If we should refer to the judgment in R (Burke) in detail, which we would have very much liked to do so, it would add to the bulk of this

Report. So far as the common law principles referred to in the Judgment are concerned, we do not propose to refer to them in as much as most of the decisions quoted in the Judgment have already been discussed by us in this Chapter.

The judgment of Munby J summarises a large number of judgments of UK and the European Court at Strasbourg and will be very helpful for researchers, except for his views on the validity of GMC guidelines which have not been accepted by the Court of Appeal. We shall refer to the Judgment of the Court of Appeal in detail, hereinbelow. (see item 34 below)

(33) Portsmouth NHS Trust vs. Wyatt & Others: (2004) EWHC 2247 (Hedley J) (7<sup>th</sup> October 2004)

The child was born on 21<sup>st</sup> October 2003 at 26 weeks gestation and weighing about 1 lb. She was placed in an incubator and had, in fact, never left the hospital. She had severe respiratory failure requiring ventilation for most of her first 3 months. She had pulmonary hypertension resulting in damage to the lungs with recurrent urinary tract infection and worsening kidney function. Her heart size was small. There was not much possibility of brain growth. She was experiencing pain. In July 2004, she suffered severe infection and was in ICU in Southampton Hospital. She was assessed there and also at Portsmouth.

(In an earlier judgment dated 30.9.2004, Hedley J held that doctors and hospital must be given anonymity.) The patient required very high levels of oxygen to be able to breathe – not nasally, but by a mechanism

which covered her head with a transparent plastic box and from it she received maximum oxygen. This method itself damaged the lungs. She therefore required ventilation. Kidneys were deteriorating, there was no chance of transplant. She could only have dialysis.

Parents wanted treatment to be given. All the doctors felt that artificial ventilation even when required, would not be good for her. The Judge observed that the doctors were bound to follow the guidance by the British Medical Association on ‘Withholding and Withdrawing life Prolonging Medical Treatment’ (2001 at that time), but that guidance was not binding on the Court though ‘entitled to the closest attention and deep respect’.

It was the unanimous opinion of doctors that artificial ventilation, if required at any stage, was in her best interests under ss 2, 3 of Children’s Act, 1989 and parental responsibility was recognized. That included the right to consent to or refuse treatment. No one else had it, save the Court, where, as here, its jurisdiction had been invoked.

Hedley J referred to R (Burke) vs. GMC: 2004 EWHC 1874 by Munby J and proposed to apply the law as laid down therein. (As stated earlier, the judgment of Munby J to the extent the Judge held that certain GMC guidelines violated the European Convention, was set aside by the Court of Appeal.) He said:

“This case evokes some of the fundamental principles that undergird our humanity. They are not to be found in Acts of Parliament or decisions of the Courts but in the deep recesses of the common psyche of humanity whether they be attributed to humanity being

created in the image of God or whether it be simply a self-defining ethic of a generally acknowledged humanism.”

and referred to the ‘sanctity of life’, ‘individual’s autonomy’, and ‘dignity of the human being’ as adumbrated by Hoffman LJ in the Court of Appeal in Airedale.

But here, the child had these rights but she was not able to exercise a choice of her own. That was done usually by her parents, but here it could be done by the Court, as to what was in her best interests. But interest encompasses medical, emotional and all other welfare issues (Re A : 2000 (1) FLR 549 (President) and Re S: 2001 Jan 15 (Thorpe LJ). He said that the “infinite variety of the human conditions never cease to surprise and it is that fact that defeats any attempt to be more precise in a definition of best interests.” He referred then to Lord Donaldson MR and Taylor LJ in Re J: 1991 Fam 33 on the balancing exercise by the Court. He stated that it becomes necessary to find out if the condition would become ‘intolerable’ for the patient so as to require stoppage of treatment in its best interests. He referred to Thorpe LJ in Re A: 2000(1) FLR 549 (at 560).

Hedley J then said: “Given that death is the one experience (other than birth) that all humanity must share, no view of life that does not include a contemplation of the place of death, even in a child, can be complete. As a society, we fight shy of pondering in death, yet inherent in each of us is a deep desire both for oneself and for those we love for a ‘good’ death. It seems to me, therefore, that in any consideration of best interests in a person at risk of imminent death is that of securing a ‘good’ death. He then refers to Taylor LJ words in Re J (1991) Fam 33 as follows:

“Despite the Court’s inability to compare a life afflicted by the most severe disability with death, the unknown, I am of the view that there must be extreme cases in which the Court is entitled to say: ‘The life which this treatment would prolong would be so cruel as to be intolerable’..... in those circumstances, without there being any question of deliberately ending the life or shortening it. I consider the Court is entitled in the best interests of the child to say that deliberated steps should not be taken artificially to prolong its miserable life span”

“..... At what point in the scale of disability and suffering ought the Court to hold that the best interests of the child do not require further endurance to be imposed by positive treatment to prolong its life? Clearly, to justify withholding treatment, the circumstances would have to be extreme.... I consider the correct approach is for the Court to judge the quality of life the child would have to endure if given the treatment and decide whether in all the circumstances such a life would be so afflicted as to be intolerable to that child. I say “to that child” because the test should not be whether the life would be tolerable to the decider. The test must be whether the child in question, if capable of exercising sound judgment, would consider the life tolerable.”

After considering the (i) relevant factors for the purpose of assessment of her best interests, (ii) the views of the parents and (iii) the guardians’ position, Justice Hedley held:

“Subject to two observations that I wish to make at the end of this judgment, I do not believe that any further aggressive treatment, even if necessary to prolong life, is in her best interests. I know that that may mean that she may die earlier than otherwise she might have done but in my judgment, the moment of her death will only be slightly advanced. I have asked myself: what can now be done to benefit Charolotte? I can only offer three answers: first, that she can be given as much comfort and as little pain as possible; secondly, that she can be given as much time as possible to spend physically in the presence of and in contact with her parents; thirdly, that she can meet her end whenever that may be in what Mr. Wyatt called the TLC of those who love her most. Although I believe and find that further invasive and aggressive treatment would be intolerable to Charolotte, I prefer to determine her best interests on the basis of finding what is the best that can be done for her.....

I propose to grant relief broadly along the lines contended for by the Hospital and Guardian, although I said that I would put over any argument about the exact wording until I had given judgment. It is not necessary for me to consider injunctive relief or any positive declaratory relief in the light of the conclusions to which I have come on best interests. I say no more than that the former (at least in mandatory terms) is currently precluded by the Court of Appeal decision in Re J (a Minor)(Child Care: Medical Treatment): 1993 Fam 15, whilst the latter raises very considerable practical difficulties.

I said that I had two further observations to make. First this relief is only permissive, it does not relieve them of the right or responsibility for advising or giving the treatment that they and the parents think right in the light of the circumstances as they develop. All it does is to authorize them, in the event of disagreement between the parents and themselves, not to send the child for artificial ventilation or similar aggressive treatment. Secondly, I would like to ask the treating doctors (without in anyway suggesting an answer to them) to give further consideration to an elective tracheotomy on the basis of its possible contribution to Charlotte's palliative care as described by Dr. G."

(34) GMC vs. Burke: (2005) EWCA (Civ) 1003: (CA)

(Lord Phillips of Worth Matravers, MR, Waller and Wall LJ)  
(d. 28.7.2005)

This is one of the most useful judgments on the various related aspects of the subject.

It was an appeal by the General Medical Council against the judgment of Munby J (2004 EWHC 1879 Admn) (already referred to) dt. 30<sup>th</sup> July, 2004.

Out of six declarations granted by the learned Judge, three related to medical treatment of Mr. Burke while three other declarations held that a number of paragraphs of the Guidance published by the General Medical Council in August 2002 (on Withholding and Withdrawing Life-Prolonging

Treatment: Good Practice and Decision Making) were violative of the European Convention. The GMC was aggrieved by the declarations. As stated while dealing with Justice Munby's judgment, the declarations were sought by the patient himself i.e. Mr. Burke.

The evidence in the case was that Mr. Burke will remain competent until the final stage of his disease. He will thus be competent to take decisions except at the final stages of his case, when he may first lose his ability to communicate though he will be conscious but later, he will go into coma. During the final stages, ANH (Artificial Nutrition and Hydration) will not be capable of prolonging his life. Mr. Burke wanted that ANH should not be withdrawn at the earlier stages when he is able to communicate.

The Court of Appeal held that there was no question of withdrawing ANH if Mr. Burke was able to communicate. The GMC guidelines did not say that ANH could be withdrawn when the patient is able to communicate.

The Judges of the Court of Appeal did not agree with Munby J who, according to them, stated that patient's view of his best interests must prevail over the view of the doctors. However, the Court of Appeal held that 'best interests' is an objective test to be applied by the doctors, while the patient's view is based on his right of 'self-determination'. They said that:

“Where a patient makes it clear that he does not wish to receive treatment which is, objectively, in his medical best interests, it is

unlawful for doctors to administer that treatment. Personal autonomy or the right of self-determination prevails”

They, however, observed that the patient cannot decide about medical best interests. They said:

“Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. Insofar as a doctor has a legal objection to provide treatment, this cannot be founded simply upon the fact that the patient demands it. The source of duty lies elsewhere”

So far as ANH is concerned, there is no need to look far for the duty to provide this. Once a patient is accepted into a hospital, the medical staff come under a positive duty at common law to care for the patient. A fundamental aspect of this positive duty of care is a duty to take such steps as are reasonable to keep the patient alive. Where ANH is necessary to keep the patient alive, the duty of care will normally require the doctors to supply ANH. This duty will not, however, override the competent patient’s wish not to receive ANH. Where the competent patient makes it plain that he or she wishes to be kept alive by ANH, this will not be the source of the duty to provide it. The patient’s wish will merely underscore that duty.

The duty to keep a patient alive by administering ANH or other life prolonging treatment is not absolute, the exceptions have been restricted to two situations: (1) where the competent patient refuses to receive ANH and

(2) where the patient is not competent and it is not considered to be in the best interests of the patient to be artificially kept alive. It is with the second exception that the law has most difficulty. The Courts have accepted that where life involves an extreme degree of pain, discomfort or indignity to a patient, who is sentient but not competent and who has manifested no wish to be kept alive, these circumstances may absolve the doctors of the positive duty to keep the patient alive. Equally, the Courts have recognized that there may be no duty to keep alive a patient who is in a persistent vegetative state (PVS). In each of these examples, the facts of the individual case may make it difficult to decide whether the duty to keep the patient alive persists.

In the case of Mr. Burke, no such difficulty arose because he was sentient, competent and he wished to be kept alive, regardless of the pain, suffering or indignity of his condition. The doctor's duty to keep the patient alive is not therefore called in question. Lord Phillips said:

“Indeed, it seems to us that for a doctor deliberately to interrupt life-prolonging treatment in the face of a competent patient's express wish to be kept alive, with the intention of thereby terminating the patient's life, would leave the doctor with no answer to a charge of murder”

Lord Phillips then went into the question whether ‘withdrawal of ANH’ contrary to the wishes of Mr. Burke infringes Articles 2, 3 and 8 of the European Convention. Articles 2, 3 and 8 read as follows:

“Art. 2      1.      Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution

of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:

- a. in defence of any person from unlawful violence;
- b. in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
- c. in action lawfully taken for the purpose of quelling a riot or insurrection.”

“Art. 3 No one shall be subjected to torture or to inhuman or degrading treatment or punishment.”

“Art. 8 1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”

The learned Judge agreed with Munby J where he had stated as follows:

“..... Art. 2 does not entitle anyone to continue life-prolonging treatment where to do so would expose the patient to ‘inhuman or degrading treatment’ breaching Art. 3. On the other hand, a withdrawal of life-prolonging treatment which satisfies the exacting requirements of the common law, including a proper application of the intolerability test, and in a manner which is in all other respects compatible with the patient’s rights under Art. 3 and Art. 8 will not, in my judgment, give rise to breach of Art. 2”

Having approved this passage from Justice Munby’s judgment, Lord Phillips clarified:

“We endorse this conclusion. It does not, however, lead to the further conclusion that if a National Health doctor were deliberately to bring about the death of a competent patient by withdrawing life-prolonging treatment contrary to that patient’s wishes, Art. 2 would not be infringed. It seems to us that such conduct would plainly violate Art. 2. Furthermore, if English law permitted such conduct, this would also violate this country’s positive obligation to enforce Art. 2. As we have already indicated, we do not consider that English criminal law would countenance such conduct. However, the fact that Arts. 2, 3 and 8 of the Convention may be engaged does not, in our judgment, advance the argument or alter the common law.”

The Court of Appeal, therefore, held that the doctor who is in charge of the Mr. Burke would himself be obliged, so long as the treatment was

prolonging Mr. Burke's life, to provide ANH in accordance with his expressed wish. This is not in doubt either.

The Court of Appeal then dealt with the validity of paras 13, 16, 32, 42 and 81 of the Guidelines (hereinafter called 'Guidance') issued by the GMC.

Is the Guidance compatible with the duty of a doctor to administer ANH to a competent patient where this is necessary to keep the patient alive and the patient expresses to be kept alive. We shall first refer to these paras of the Guidance.

Para 13 of the Guidance deals with the right of adult patients to refuse treatment. It has no reference to the duty of the doctor to provide ANH. It has no bearing on the present case.

Para 16 of the Guidance deals with the differences in choice by patients based on different values, beliefs and priorities which doctors must take into account. Where, however, a patient wants treatment which the doctors feel is not clinically indicated, they have no ethical or legal obligation. The Court of Appeal felt that para 16 has no relevance to the case of ANH, except where a patient demands ANH during terminal stages where it is not going to prolong life. This was an unlikely scenario and not one that can properly concern Mr. Burke at this stage of his illness.

Para 32 of the Guidance states that it is the doctor's responsibility to make a decision about whether to withhold or withdraw a life-prolonging

treatment, taking into account the views of the patient or those close to the patient. Exceptionally, in an emergency where the senior clinician cannot be contacted in time, if the doctor is appropriately experienced, a junior hospital doctor or deputizing general practitioner may take responsibility for making the decision but it must be discussed with the senior clinician as soon as possible. On this, the Court of Appeal observed as follows:

“This is part of the general framework of the guidance and not specifically directed to the provision, or withdrawal of ANH. We accept that, if read in isolation, the phrase ‘taking into account of the views of the patient’, might suggest that a consultant or general practitioner in charge of a patient’s case could withhold or withdraw ANH, contrary to the expressed wish of a competent patient if he considered that there was good reason for disregarding his wish. Taken in the context of the Guidance as a whole, however, we do not consider that any reasonable doctor would conclude from para 32 that it would be permissible to withdraw life-prolonging treatment with a view of ending a patient’s life despite the patient’s expressed wish to be kept alive.”

Para 42 of the Guidance stated that a doctor should bear in mind that he is bound to respect an adult patient’s refusal of treatment, made competently, even where complying with the decision will lead to the patient’s death. If a specific treatment is requested which, in the doctor’s considered view is clinically inappropriate, the doctor is not legally or ethically bound to provide it. However, he should give the patient a clear

explanation of the reasons for his view, and respect the patient's request to have a second opinion. The Court of Appeal stated:

“We understand that it is the second half of this paragraph that the Judge considered objectionable. This could only be relevant to Mr. Burke's predicament if one postulates that a doctor might consider it 'clinically inappropriate' to keep him alive by administering ANH despite his wishes that this should be done. We consider such a scenario to be totally unrealistic”

Para 81 of the Guidance states that where patients have capacity to decide, they may consent or refuse to any proposed intervention of any kind. Where patients lack capacity to decide, the doctors should take into account various circumstances:

- (i) provide ANH for a trial-period, if there is reasonable uncertainty about the likely benefits or burdens of ANH;
- (ii) where death is imminent, it is not appropriate to start artificial hydration or nutrition, although artificial hydration can be provided to give symptom-relief;
- (iii) where death is imminent and artificial hydration and/or nutrition are already in use, it may be appropriate to withdraw them if it is considered that the burdens outweigh the possible benefits of the patient;
- (iv) where death is not imminent, it usually will be appropriate to provide artificial nutrition and hydration. However, if the patient's condition is so severe and progress is so poor that

artificial nutrition or hydration may cause suffering, a senior clinician (who might be from another discipline such as nursing) may have to be consulted.

The Court of Appeal, in relation to para 81 of the Guidance observed as follows:

“This is the only paragraph to which the Judge has taken exception that deals expressly with ANH. The first sentence requires the doctor to comply with the expressed wishes of a patient with capacity. No exception can be taken to this. The remainder deals with the approach to be taken where the patients lack capacity to decide for themselves and their wishes cannot be determined. We cannot see that this has any relevance to Mr. Burke’s predicament”

For the above reasons, the Court of Appeal did not consider that insofar as the Guidance related to Mr. Burke, there was any ground for declaring them unlawful.

The Court of Appeal then identified certain topics from Justice Munby’s judgment which required some elucidation of law:

- (i) The right of a patient to select the treatment that he will receive;
- (ii) The circumstances in which life-prolonging treatment can be withdrawn from a patient who is incompetent;
- (iii) The duty to seek the approval of Court before withdrawing life-prolonging treatment.

(i) Right of patient to select the treatment that he will receive:

It is not correct to say that Justice Munby opined that a doctor is obliged to render treatment which is not clinically indicated, merely because the patient wants it. The GMC's submissions to the following effect are correct:

- (a) The doctor, exercising this professional clinical judgment, decides what treatment options are clinically indicated (i.e. will provide overall clinical benefit) for his patient.
- (b) He then offers those treatment options to the patient in the course of which he explains to him/her the risks, benefits, side-effects etc. involved in each of the treatment options.
- (c) The patient then decides whether he wishes to accept any of those treatment options and, if so, which one. In the vast majority of cases, he will, of course, decide which treatment option he considers to be in his best interest and, in doing so, he will or may take into account other, non-clinical, factors. However, he can, if he wishes, decide to accept (or refuse) the treatment option on the basis of reasons which are irrational or for no reasons at all.
- (d) If he chooses one of the treatment options offered to him, the doctor will then proceed to provide it.
- (e) If, however, he refuses all of the treatment options offered to him and instead informs the doctor that he wants a form of treatment which the doctor has not offered him, the doctor will, no doubt, discuss that form of treatment with him (assuming that it is a form

of treatment known to him) but if the doctor concludes that this treatment is not clinically indicated, he is not required (i.e. he is under no legal obligation) to provide it to the patient although he should offer to arrange a second opinion.

The Court of Appeal, however, reiterated that so far as a competent patient is concerned, if he wanted to be kept alive by ANH, a doctor cannot refuse and if he refuses, it will amount to murder. “Where life depends upon continued provision of ANH, there can be no question of the supply of ANH not being clinically indicated unless a clinical decision has been taken that the life in question should come to an end. That is not a decision that can be taken in the case of a competent patient who expresses the wish to remain alive.”

As to when ANH is not clinically indicated, it may be, even in the case of a competent patient, that at the last stage of life, ANH may hasten death rather than prolong it, and at that stage, whether to administer ANH or not, will be a clinical decision which is likely to turn on whether or not it has a palliative effect or is likely to produce adverse reactions. “It is only in this situation that, assuming the patient remains competent, a patient’s expressed wish that ANH be continued, might conflict with the doctor’s view that this is not clinically indicated.”

In such a situation, Lord Phillips stated, disagreeing with Munby J, that the patient’s wish is not determinative of the treatment. “Clearly, the doctor would need to have regard to any distress that might be the cause as a result of overriding the expressed wish of the patient. Ultimately, however,

a patient cannot demand that a doctor administer a treatment which the doctor considers adverse to the patient's clinical interests. This said, we consider that the scenario we have just described is extremely unlikely to arise in practice."

(ii) Position of the incompetent patient:

The position of a PVS is already decided by the House of Lords in Airedale vs Bland. But, the Court of Appeal clarified that to keep a PVS patient alive merely because of his advance directive, will violate the Mental Capacity Act, 2005. They said, explaining Airedale, as follows:

"... We do not consider it appropriate to add to what was said by their Lordships (in Bland), other than to make the following observation. While a number of their Lordships indicated that an advance directive that the patient should not be kept alive in a PVS should be respected, we do not read that decision as requiring a patient to be kept alive simply because he has made an advance directive to that effect. Such a proposition would not be compatible with the provisions of the Mental Capacity Act, 2005, which we consider accords with the position at common law. While sec. 26 of that Act requires compliance with a valid advance directive to refuse treatment, sec. 4 does no more than require this to be taken into consideration when considering what is in the best interests of a patient."

He continued:

“There are tragic cases where treatment can prolong life for an indeterminate period, but only at a cost of great suffering while life continues. Such a case was In re J (a Minor) (Wardship: Medical Treatment) (1991 Fam 33). There are other cases and these are much more common, where a patient has lost competence in the final stages of life and where ANH may prolong these final stages, but an adverse cost so far as comfort and dignity are concerned, sometimes resulting in the patient’s last days being spent in a hospital ward rather than at home, with family around.

It is to these situations that so much debate in this case has been directed. Apprehensions have been expressed by some who have intervened that those in charge of patients may too readily allow, or fail to provide, ANH or other life prolonging treatment on the ground that the patient’s life, if prolonged, will not be worth living. As an example of the first situation described above, the Disability Rights Commission brought to our attention the disturbing story of Jane Campbell. She suffers from spinal muscular atrophy and is severely disabled. She was not expected to live beyond the age of four but has lived a fulfilling and productive life of high achievement. In 2003, she was struck down by pneumonia. Two consultants were minded to conclude that her life was so parlous that, if she needed artificial respiration to remain alive, she would not wish to receive it. Only the intervention of her husband, who showed them a photograph of her taking her degree, persuaded the consultants that her life was worth saving.”

The Court of Appeal referred then to some disturbing reports of the Medical Ethics Alliance which were placed before the Joint Committee of Parliament on the draft Mental Incapacity Bill. These were cases where patients who were terminally ill appear to have been denied water and nutrition in circumstances where this was contrary to the demands of palliative care. The Reports underlined the importance of clear case law and guidance. The Court of Appeal approved Justice Munby's opinion in this context except for the last two sentences underlined. Munby J had said:

“There is a very strong presumption in favour of taking all steps which will prolong life, and save in exceptional circumstances, or where the patient is dying, the best interests of the patient will normally require such steps to be taken. In case of doubt, that doubt falls to be resolved in favour of the preservation of life. But the obligation is not absolute. Important as the sanctity of life is, it may have to take second place to human dignity. In the context of life-prolonging treatment, the touchstone of best interest is intolerability. So if life prolonging treatment is providing some benefit, it should be provided unless the patient's life, if thus prolonged, would from the patient's point of view be intolerable.”

After approving the earlier part of the extract, the Court of Appeal commented on the last two sentences as follows:

“We do not think that any objection could have been taken to this summary had it not contained the final two sentences, which we have

emphasised. The suggestion that the touch stone of ‘best interests’ is the ‘intolerability’ of continued life has, understandably given rise to concern. The test of whether it is in the best interests of the patient to provide or continue ANH must depend upon the particular circumstances. The two situations that we have considered above are very different. As to the approach to be adopted to the former, the Court dealt with that in Re J and we do not think it appropriate to review what the Court there said in a context that is purely hypothetical.”

As regards the ‘best interests’ of a patient close to death, the Court of Appeal observed that the Judge Munby himself recognized that ‘intolerability’ was not the test of ‘best interests’ and that the following words of Munby J were correct:

“where the patient is dying, the goal may properly be to ease suffering and, where appropriate, to ‘ease the passing’ rather than to achieve a short prolongation of life”

and the Court of Appeal continued:

“We do not think it possible to attempt to define what is in the ‘best interests’ of a patient by a single test, applicable in all circumstances. We would add that the disturbing cases referred to in paragraphs 57 and 58, if correctly reported, were cases where the doctors appear to have failed to observe the Guidance. They are not illustrative of any illegality in the Guidance. The Guidance expressly warns against

treating the life of a disabled patient as being of less value than the life of a patient without disability, and rightly does so”

(iii) Is there a legal requirement to obtain Court authorization before withdrawing ANH in every one of the cases specified by Munby J?

Munby J had declared that ‘in certain circumstances’, this question must be answered in the affirmative. He listed five categories of cases and observed that paras 38 and 82 of the Guidance are therefore illegal. These categories are as follows:

- (i) where there is any doubt or disagreement as to the capacity (competence) of the patient; or
- (ii) where there is lack of unanimity amongst the attending medical professions as to either
  - (a) the patient’s condition or prognosis; or
  - (b) the patient’s best interests; or
  - (c) the likely outcome of ANH being either withheld or withdrawn; or
  - (d) otherwise as to whether or not ANH should be withheld or withdrawn; or
- (iii) where there is evidence that the patient when competent would have wanted ANH to continue in the relevant circumstances; or
- (iv) where there is evidence that the patient (even if a child or incompetent) resists or disputes the proposed withdrawal of ANH; or

- (v) where persons having a reasonable claim to have their views or evidence taken into account (such as parents or close relatives, partners, close friends, long term carers) assert that withdrawal of ANH is contrary to the parents' wishes or not in the patient's best interest."

Para 38 of the Guidance requires that a clinician with relevant experience be consulted (from another discipline such as nursing) where the doctor has limited experience or is in doubt about options or the patient is not likely to die immediately or there are differences among the doctors. Para 82 says that where significant conflicts arise about whether artificial nutrition or hydration should be provided, either between doctors and other members of the health team or those close to the patient, and it is not possible to resolve the conflict, the doctor should seek legal advice.

The Court of Appeal held that even assuming that the five situations mentioned by Munby J are cases where the Court has to be approached, the Guidance paras 38 and 82 are not unlawful merely because they do not state that Court sanction is required in such cases.

The Court of Appeal learnt from the Intensive Care Society (ICS) that each year approximately 50,000 patients are admitted to ICU and out of these 30% die in ICU or in the wards before discharge. Most of these die because treatment is withdrawn or limited, where the treatment would have merely prolonged the process of dying.

But, if Munby J's directions for approaching Court in all the five contingencies, were to be accepted, the ICS said that every day 10 applications have to be made to the Court and this would be impractical.

The Court of Appeal held:

“In the event, we do not consider that the Judge is right to postulate that there is a legal duty to obtain Court approval to the withdrawal of ANH in the circumstances that he identifies”

They said that it may be a matter of ‘good practice’ to obtain Court approval but it cannot be made mandatory in every case, even where there are differences. Munby J had however observed that after the judgment of the European Court in Glass v. UK: 2004 (1) FLR 1019 (= 2004 Lloyds Rep Med 78), what under English law was a ‘rule of practice’ had become a ‘rule of law’. The Court of Appeal examined this aspect by referring to the facts in Glass v. UK in detail and found that the European Court merely held that, on the facts, the doctors, who were treating a minor whose guardian (mother) did not consent to administration of diamorphine, had ample time to move Court and that the doctors failed to do so. The European Court had not laid down any rule of law. It pointed that the case was not one of emergency. The observations of Munby J were, therefore, not accepted.

Before we part with this case, we have to refer to para 71 of the judgment of the Court of Appeal which deals with the question whether the Court which is approached is indeed making lawful what is otherwise unlawful. The Court said that is not the effect of the declaration. This is only a matter of ‘good practice’. It referred to Airedale as follows:

“We asked the Gordon to explain the nature of the duty to seek the authorization of the Court and he was not able to give us a coherent explanation. So far as the Criminal Law is concerned, the Court has no power to authorize that which would otherwise be unlawful – see for instance the observation of Lord Goff of Chievley in Bland at p. 785H. Nor can the Court render unlawful that which would otherwise be lawful. The same is true in relation to a possible infringement of Civil Law. In Bland, the House of Lords recommended that, as a matter of good practice, reference should be made to the Family Court before withdrawing ANH from a patient in a PVS, until a body of experience and practice had built up. Plainly, there will be occasions in which it will be advisable for a doctor to seek the Court’s approval before withdrawing ANH in other circumstances, but what justification is there for postulating that he will be under a legal duty to do so”

The Court of Appeal held it was not a matter of ‘legal duty’ but only of ‘good practice’.

Chapter – VLeading case law and statutes in United States of America

In this chapter, we shall refer to some leading judgments from USA and also refer to some of the pieces of legislation.

(A) USA (Federal):

(1) Cruzan vs. Director, MDH: (1990) 497 US 261 (dated 25<sup>th</sup> June 1990)

(Rehnquist CJ delivered the opinion, in which White, Sandra Day O'Connor, Scalia and Kennedy JJ joined. O'Connor and Scalia J filed concurring opinions. Brennan J filed a dissenting opinion in which Marshall and Blackmun JJ joined. Stevens filed a separate dissenting opinion).

Nancy Cruzan met with a motor accident on January 11, 1983, while she lost control of her car, the vehicle overturned and went down Elm Road in Jasper County, Missouri. She has been in Mission State Hospital, in a Persistent Vegetative State (PVS), where she only exhibits motor reflexes but evinces no indication of significant cognitive function. The State is bearing the cost of her care. Cruzan's parents requested for termination of her artificial nutrition and hydration but the hospital refused, since that would result in her death. The State trial Court authorized termination but the State Supreme Court refused to so authorize. While recognizing a right, on part of a patient, to refuse treatment under common law doctrine of informed consent, the Court questioned applicability of the said principle to

this case. It declined to read into the State Constitution a broad right to privacy that would support an unrestricted right to refuse treatment and expressed doubt if the Federal Constitution embodied such a right. The Court then decided that the State's Living Will statute embodied a state policy strongly favouring the preservation of life and that Cruzan's statements to her housemate were unreliable for the purpose of determining her intent. It rejected the argument that the parents were entitled to order termination of her medical treatment. It concluded that no person can assume that choice for an incompetent person, in the absence of the formalities required by the Living Will Statute or in the absence of clear and convincing evidence of the patient's wishes.

The US Supreme Court affirmed the judgment and held that (1) the State of Missouri was competent to require that the incompetent's prior wish as to withdrawal of life sustaining treatment, should be proved by 'clear and convincing' evidence. (Here the plea about the patient's earlier words, while conscious, that she did not wish to live unless at least one half of normal life was assured by treatment, was not substantiated by clear and convincing evidence);

(2) Most State Courts in US have based a right to refuse treatment on the basis of the common law right to informed consent or on both that right and a constitutional privacy right. Courts have also turned to guidance from State statutes;

(3) A competent person is at liberty under Due Process Clause in refusing unwanted medical treatment (Jacobson vs. Massachusetts: 197 US 11). However, the question whether that constitutional right has been violated, must be determined by balancing the liberty interest against relevant State

interests. For purposes of this case, it is assumed that a competent person would have a constitutionally protected right to refuse life-saving hydration and nutrition. This does not mean that an incompetent person should possess the same right, since such a person is unable to make an informed and voluntary choice to exercise that hypothetical right or any other right. While State of Missouri has, in effect, recognized that, under certain circumstances, a surrogate may act for the patient in electing to withdraw hydration and nutrition and thus cause death, it has established a procedural safeguard to assure that surrogate's action conforms, as best as it may, to the wishes expressed by the patient while competent;

(4) It is permissible for the Missouri State, in its proceedings, to apply a 'clear and convincing' evidence standard, which is an appropriate standard when the individual interests at stake are both particularly important and more substantial than mere loss of money (Santosky vs. Kramer: 455 US 745). The State of Missouri has a general interest in the protection and preservation of human life, as well as other, more particular interests, at stake. It may legitimately seek to safeguard the personal element of an individual's choice between life and death. The State is also entitled to guard against potential abuses by surrogates who may not act to protect the patient.

(5) Similarly, the State is entitled to consider that a judicial proceeding regarding an incompetent's wishes may not be adversarial, with the added guarantee of accurate fact finding that the adversary process begins with it.

(6) The State may also decline to make judgments about the 'quality' of a particular individual's life, and simply assent an unqualified interest in the preservation of human life to be weighed against the constitutionally

protected interests of the individual. The clear and convincing evidence standard also serves as a societal judgment about how the risk of error should be distributed between the litigants. Missouri State may permissibly place the increased risk of an erroneous decision on those seeking to terminate life-sustaining treatment. An erroneous decision not to terminate, results in a maintenance of the status quo, with at least the potential that a wrong decision will eventually be corrected or its impact mitigated by an event such as an advancement in medical science or the patient's unexpected death. However, an erroneous decision to withdraw such treatment is not susceptible of correction. Although the Missouri State's proof requirement may have frustrated the effectuation of Cruzan's not-fully expressed desires, the Constitution does not require general rules to work flawlessly.

(7) On facts, it was held that the State Supreme Court did not commit any constitutional error in concluding that the evidence adduced at the trial did not amount to clear and convincing proof of Cruzan's desire for withdrawal of hydration and nutrition. The trial Court had not adopted a 'clear and convincing' evidence standard, and Cruzan's observation that she did not want to live life as a 'vegetable' did not deal in terms with withdrawal of medical treatment or of hydration and nutrition.

(8) The 'Due Process' clause does not require a State to accept the 'substituted judgment' of close family members in the absence of substantial proof that their views reflect the patient's. The US Supreme Court's decision upholding the State's favoured treatment of traditional family relationships, Michael H vs. Gerald D 491 US 110, may not be turned into a constitutional requirement that a State must recognize the

primacy of these relationships in a situation like this. Nor may a decision upholding a State's right to permit family decision-making, Parham vs. J.R. 442 US 584, be turned into a constitutional requirement that the State must recognize such decision-making. Cruzan's parents would surely be qualified to exercise such a right of 'substituted judgment', were it required by the Constitution. However, for the same reasons that Missouri State may require a clear and convincing evidence of the patient's wishes, it may also choose to defer only to those wishes, rather than confide the decision to close family members.

Having set out the head-note as it occurs in the law report, we shall now refer to certain other important principles laid down in the judgment delivered by Rehnquist CJ:

At Common Law, even the touching of one person by another without consent and without legal justification was a battery. The notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. Justice Cardozo, while on the Court of Appeals of New York, aptly described this doctrine: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault, for which he will be liable in damages". Schloendorff vs. Society of New York Hospital: (1914) 211 NY 125. The informed consent doctrine has become firmly entrenched in American tort law.

The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is to refuse treatment. When In re Quinlan 70 NJ 10 was decided, there were a few

cases of treatment being refused, but now during the years 1976-1988, there have been 54 reported cases. According to Prof Tribe, in his *American Constitutional Law*, (2<sup>nd</sup> ed. 1988), such a right is available under Common Law as also under the Constitutional law. The right to self-determination was not lost because the patient was incompetent. It would be exercised by a 'surrogate' using a 'subjective' standard when there was clear evidence that the incompetent person would have exercised it. Where such evidence was lacking, an incompetent person's right could still be invoked under the 'objective' and 'best interests' standards.

The Fourteenth Amendment provides that no State shall 'deprive any person of life, liberty, or property, without due process of law'. It protects an interest in life as well as an interest in refusing life sustaining medical treatment. Where surrogates are not available or cannot take a decision, a State is entitled to guard against potential abuses and decline to make judgments about the 'quality' of life and simply assent an unqualified interest in preservation of human life to be weighed against the constitutionally protected interests of the individual. The State of Missouri sought to advance these interests through the adoption of a 'clear and convincing' standard of proof to govern such proceedings. Such a higher standard is necessary to prevent erroneous decisions that may be made to terminate life which if they led to the death of the patient, the situation would be irreversible. An erroneous decision to withdraw life-saving treatment is not susceptible of correction.

The Court said: "In sum, we conclude that a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a

persistent vegetative state. We note that many Courts which have adopted some sort of substituted judgment procedure in situations like this, whether they limit consideration of evidence to the prior expressed wishes of the incompetent individual or whether they allow more general proof of what the individual's decision would have been, require a clear and convincing standard of proof of such evidence.”

In this case, the testimony adduced at trial consisted primarily of Nancy Cruzan's statements, made to a house-mate about a year before her accident, that she would not want to live, should she face life as a 'vegetable', and she is said to have made other observations to the same effect. The observations did not deal in terms with withdrawal of medical treatment or of hydration and nutrition.

The parents of Cruzan would qualify for being persons who could make the 'substituted judgment' if a State permitted or required such a judgment but there is no acceptance that the view of close family members will necessarily be the same as the patient's would have been, had she been confronted with the prospect of her situation while competent. The State law required the clear and convincing evidence of the patient's wishes rather than confine the decision to close family members. (The case obviously was treated as not raising surrogate rights).

Sandra Day O'Connor, in her concurring Judgment, made it clear that the case before the Court did not have to do with the validity of a surrogate's decision. Having said that, she referred to the modern techniques of ventilator and artificial nutrition as amounting to administering 'medical treatment' and that the Due Process Clause protects a patient's right to refuse such 'medical treatment'. As to surrogates, States

could require a clear and convincing evidence standard. The patient's appointment of a proxy to make a proxy to make healthcare decision has been accepted by several States and that some Courts are also accepting such a procedure of appointment by a durable power of attorney. Some States allow an individual to designate a proxy to carry out the intent of a living will. Giving effect to a proxy's decisions may also protect the 'freedom of personal choice in matters of family life' as stated in Cleveland Board of Education vs. La Flem (1974) 414 US 632. She pointed out that at least 13 States (details of which she gave in fn 2) and District of Columbia have passed statutes that durable powers of attorney could be issued authorizing appointing of proxies for making health care decisions. (Most of these States started in 1989). Thirteen States have 'living will' statutes authorizing the appointment of health care proxies.

Scalia J, in a concurrent judgment traced the history of illegality of suicide and assisted suicide over centuries but observed that the right to refuse treatment was based on the dichotomy between action and inaction. He said:

"Suicide, it is said, consists of an affirmative act to end one's life; refusing treatment is not an affirmative act 'causing' death, but merely a passive acceptance of the natural process of dying. I readily acknowledge that the distinction between action and inaction has some bearing upon the legislative judgment of what ought to be prevented as suicide – though even there, it would seem to me unreasonable to draw the line precisely between action and inaction, rather than between various forms of inaction. It would not make much sense to say that one may not kill oneself by walking into the

sea, but may sit on the beach until submerged by the incoming tide, or that one may not intentionally lock oneself into a cold storage locker but may refrain from coming indoors when the temperature drops below freezing. Even as a legislative matter, in other words, the intelligent line does not fall between action and inaction, but between those forms of inaction that consist of abstaining from ‘ordinary’ care and those that consist of abstaining from ‘excessive’ or ‘heroic’ measures. Unlike action vs inaction, that is not a life to be discerned by logic or legal analyses and we should not pretend that it is.”

“It is not surprising, therefore, that the early cases considering the claimed right to refuse medical treatment dismissed as specious, the nice distinction between “passively submitting to death and actively seeking it. The distinction may be merely verbal, as it would be if an adult sought death by starvation instead of a drug. If the State may interrupt one mode of self-destruction, it may with equal authority interfere with the other. John F. Kennedy Memorial Hospital vs. Heston (1971) 58 N.J. 576; see also Application of President & Directors of Georgetown College Inc. (1964) 118 US App. DC-80: 331 F 2d 1000. The third asserted basis of distinction – that frustrating Nancy Cruzan’s wish to die in the present case requires interference with her bodily integrity – is likewise inadequate, because such interference is impermissible only if one begs the question whether refusal to undergo the treatment on her own, is suicide. It has always been lawful not only for the State, but even for private citizens to interfere with bodily integrity to prevent a felony..... That general rule has of course been applied to suicide. At Common Law, even a private person’s use of force to prevent suicide

was privileged.... It is not even reasonable, much less required by the Constitution, to maintain that, although the State has the right to prevent a person from slashing his wrists, it does not have the powers to apply physical force to prevent him from doing so, nor the power, should he succeed, to apply, coercively, if necessary, medical measures to stop the flow of blood. The state-run hospital, I am certain, is not liable under 42 U.S.C. 1983 for violation of constitutional rights, nor the private hospital liable under general tort law, if, in a state where suicide is unlawful, it pumps out the stomach of a person who has intentionally taken an overdose of barbiturates, despite that person's wishes to the contrary".

Scalia J then deals with the dissent by Brennan & Stevens JJ and says:

"... the State has no such legitimate interest that could outweigh 'the person's choice to put an end to her life'..... the State must accede to her 'particularized and intense interest in self-determination in her choice whether to continue living or die.'" For, insofar as balancing the relative interests of the State and the individual is concerned, there is nothing distinctive about accepting death through the refusal of 'medical treatment', as opposed to accepting it through the refusal of food, or through the failure to shut off the engine and get out of the car after parking in one's garage after work. Suppose that Nancy Cruzan were in precisely the condition she is in today, except that she could be fed and digest food and water without artificial assistance, how is the State's interest in keeping her alive thereby increased or her interest in deciding whether she wants to continue living reduced?" (emphasis supplied)

He stated that he could not agree with Brennan & Stevens that a person could make the choice of death. That view the State has not yet taken. The Constitution does not say anything on the subject.

2) Washington et al vs. Gluckberg et al: (1997) 521 US 702

Two judgments were delivered on 26<sup>th</sup> June 1997 by the US Supreme Court, one was in Washington v. Gluckberg and the other was in Vacco, Attorney General of New York et al vs. Quill et al. (1997) 117 S.Ct 2293. Both related to the validity of a law made in different States, banning ‘assisted suicide’. The two judgments refer incidentally to Cruzan and related cases dealing with the right of a patient to refuse medical treatment. Therefore, these cases are also relevant in the present discussion.

In this case, Rehnquist CJ delivered the opinion which was concurred by O’Connor, Scalia, Kennedy and Thomas JJ. O’Connor gave a concurring opinion, in which Ginsberg and Breyer JJ joined in part. Stevens, Souter, Ginsberg and Breyer JJ each filed concurring opinions.

Here, in the State of Washington, the act of assisting suicide was always an offence. The present law makes ‘promoting a suicide attempt’ a felony and provides : “A person is guilty of (that crime) when he knowingly causes or aids another person to attempt suicide”.

The Respondents were Washington physicians who occasionally treated terminally ill, suffering patients, declared that they would assist these patients in ending their lives if the State’s assisted suicide ban was not there. They, along with three gravely ill plaintiffs (who have since died), and a non-profit organization that counsels people considering ‘physician-assisted suicide’, filed this suit against State and others seeking a

declaration that the ban was, on its face, unconstitutional. They assert a liberty interest protected by the 14<sup>th</sup> Amendment's Due Process Clause which extends to a personal choice by a mentally competent, terminally ill adult to commit suicide by medical assistance. The trial and first appellate Courts held the ban was unconstitutional.

Allowing the appeal (see Head Note), the Supreme Court held that the Washington law against 'causing' or 'aiding' suicide was not violative of the Due Process Clause. For over 700 years, assisted suicide had remained prohibited under Anglo American Common Law and it has been a crime in almost every State. The President had, in fact, signed the Federal Assisted Suicide Funding Restriction Act, 1997 which prohibits the use of federal funds in support of physician assisted suicide. The right to assist suicide is not a fundamental liberty interest protected by Due Process Clause, in the light of history. The substantive due process has two features – firstly, it protects those fundamental rights and liberties which have been, objectively considered to be deeply rooted in the American history and tradition. Secondly, the Court has required a 'careful description' of the asserted fundamental interest. The right to assist suicide claimed by the respondents runs counter to the second requirement. This asserted right has no place in the traditions of US, even for terminally ill, mentally competent adults. The contention that the asserted interest is consistent with the Court's substantive due process cases, - if not the Country's history and practice – is not persuasive. On the other hand, the constitutionally protected right to refuse treatment by use of lifesaving hydration and nutrition that was discussed in Cruzan was not simply deduced from abstract concepts of personal autonomy, but was, in fact, based on the country's history and tradition, given the Common Law rule that forced medication was a battery

and the long traditions protecting the decision to refuse unwanted medical treatment. Although, Planned Parenthood vs. Casey (1992) 505 US 833 recognised that many of the rights and liberties protected by the Due Process Clause sound in personal autonomy, it does not follow that any and all important, intimate and personal decisions are so protected (see A San Antonio Independent School District vs. Rodriguez: (1973) 411 US 1. The ban is rationally related to legitimate government interests in prohibiting intentional killing and preserving human life; preventing the serious public health problem of suicide, especially among the young and elderly and those suffering from unrelated pain or depression or other mental disorders, for protecting the medical profession's integrity and ethics and maintaining physician's role as healers of patients, protecting the terminally ill and vulnerable groups and for avoiding a possible slide towards voluntary and perhaps even involuntary euthanasia.

In the main opinion delivered by Rehnquist CJ, it was stated that the majority of States in US have laws imposing criminal penalties on those who assist suicide. In fact, over a period of 700 years, the Anglo American Common Law punished or disapproved suicide and assisted suicide. "Because of advances in medicine and technology, Americans today are increasingly likely to die in institutions, from chronic illness....Public concern and democratic action are therefore sharply focused on how best to protect dignity and independence at the end of life, with the result that there have been many significant changes in State laws and in the attitudes these laws reflect. Many States, for example, now permit 'living wills', surrogate health-care decision making, and the withdrawal or refusal of life sustaining medical treatment. ...At the same time, however, voters and legislators

continue for the most part to re-affirm their States ‘prohibitions on assisting suicide.’”

Washington passed ‘Natural Death Act, 1979’ which specifically stated that the

‘withholding or withdrawal of life sustaining treatment .... shall not, for any purpose, constitute a suicide’”

and that

“nothing in this chapter shall be construed to condone, authorize or approve mercy killing....”

(Washington Laws, Ch. 112, sec 8(1)). The Washington statute at issue in this case, i.e. banning assisted suicide is in the Washington Rev Code see 9A.36.060 1994) (see Wash Rev Code ss 70.112.070(1), 70.122.100)(1994). (However, Oregon enacted in 1994 a Death With Dignity Act, which legalized physicians assisted suicide for competent, terminally ill adults. See Oregon Rev Stet. MC 127.8N. The Act was upheld in Lee vs. Oregon: 107 F.3d 1382 (A 9, 1997). Iowa and Rhode Island too rejected assisted suicide (1997). President Clinton signed the Federal Assisted Suicide Funding Restrictive Act 1997 which prohibits the use of federal funds in support of physician assisted suicide. (Pub. L. 105-12, 111 Stat 23 codified at 42 USC para 14401 etc)”.

In Cruzan, the Court assumed that the Constitution guaranteed competent persons a ‘constitutionally protected right to refuse life saving hydration and nutrition’. The question now is whether the liberty protected

by the Due Process Clause ‘includes a right to commit suicide which itself includes a right to assistance in doing so’.

To accept this plea, the Court has to review centuries of legal doctrines and practices and strike down the considered policy choices of almost every State. If a thing has been practiced for two hundred years by common consent, it will need a strong case for the Fourteenth Amendment to affect it. (Reno v. Flores (1993) 507 US 292 at 302). Apart from history and practice, the plea runs contrary to the Court’s due process line of cases, which no doubt include ‘basic and intimate exercises of personal autonomy’. The respondents claim that the “due process clause includes a right to commit suicide with another’s assistance”, cannot be accepted.

In Cruzan, it was only stated that at common law there was the right to refuse medical treatment in the absence of which such medical intrusion would be ‘battery’. Informed consent is necessary for medical treatment. The Court there said that ‘the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment’. The Court assumed that the US Constitution would grant a competent person a constitutionally protected right to refuse life-saving hydration and nutrition’. The Court concluded that, notwithstanding that right, the Constitution permitted Missouri State to require a clear and convincing evidence of an incompetent patient’s wishes concerning withdrawal of life sustaining treatment. Rehnquist CJ said

“The decision to commit suicide with the assistance of another may be just and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct.....

In Cruzan itself, we recognized that most States outlawed assisted suicide – and even more do today – and we certainly give no intimation that the right to refuse unwanted medical treatment could be somehow transmitted into a right to assistance in committing suicide.”

Though the Due Process protection for abortion in certain situations and personal decisions regarding marriage, contraception, family relationships, child rearing, education etc. were based on a right to personal autonomy, it ‘does not warrant the sweeping conclusion that any and all important, intimate and personal decisions are so protected. “The history of the law’s treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the assisted ‘right’ to assistance in committing suicide is not a fundamental liberty interest protected by the Due process clause. The Constitution also requires, however, that Washington’s assisted suicide ban be rationally related to legitimate government interests.... This requirement is unquestionably met here. As the Court below recognized, Washington’s assisted suicide ban implicates a number of state interests. First, Washington has an ‘unqualified interest in the preservation of human life. The State’s prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to this interest... This interest is symbolic and aspirational as well as practical... The State has an interest in preventing suicide.... Research indicates, however, that many people who request physician assisted suicide withdraw that request if their depression or pain are treated...”

Rehnquist CJ also pointed out that the State has an interest in protecting the integrity and ethics of the medical profession and physician's groups and concluded that 'physician assisted suicide is fundamentally incompatible with the physician's role as healer'. And physician assisted suicide could undermine the trust that is essential to the doctor patient relationship, by blurring the time-honoured line between healing and harming.

In addition, the State has an interest in protecting vulnerable groups – including the poor, the elderly and disabled persons – from abuse, neglect and mistakes. The Court recognized the real risk of subtle coercion and undue influence in end-of-life situations. If physician assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end of life health-care costs.

The State's interest extends to protecting the disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and 'societal indifference'. The ban reflects and reinforces the policy that the lives of terminally ill, disabled and elderly people must be no less valued than the lives of the young, and healthy.

The State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia. The Court of Appeal, no doubt, struck down the ban in so far as it applied to "competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors. But the Washington law rightly insists that if the protection is a matter of constitutional right, it must apply to all persons. But, if in the process of physician assisted suicide, the family members and loved ones will inevitably participate, then it could

prove extremely difficult to police and contain. The Act prevents such erosion.”

The Court said that this concern is supported by unfortunate results of the practice of euthanasia in the Netherlands. The Dutch government’s own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia, 400 cases of assisted suicide, and more than 1000 cases of euthanasia without an explicit request. In addition to these latter 1000 cases, the study found an additional 41941 cases where physicians administered lethal morphine overdoses without the patients’ explicit consent. This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has not been limited to competent, terminally ill adults who are enduring physical suffering, and that regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia. Washington State, like most other States, reasonably ensures against the risk by banning, rather than regulating, assisted suicides.

(We are not referring to the reasons given in the other concurring opinions in this case.)

3) Vacco, Attorney General of New York et al vs. Quill et al: (1997) 117 SCt 2293.

This case refers to the validity of the New York’s statute prohibiting assisted suicide and as to how its validity was upheld after rejecting the plea that the Act violated the Equal Protection Clause.

The main opinion was given by Rehnquist CJ, with whom O’Connor, Scalia, Kennedy and Thomas joined. O’Connor filed a concurring opinion

with which Ginsburg and Breyer JJ agreed in part. Stevens, Souter, Ginsburg, Breyer filed separate opinions also.

The New York statute prohibits assisted suicide. (N.Y. Penal Law, sec. 125.19). Section 120.30 makes it an offence if a person intentionally causes or aids a person to attempt suicide. Promoting suicide attempt is a E class felony. However, N.Y. law permits refusal of medical treatment, even if the withdrawal of such treatment will result in death. N.Y. Public Health Law Art 29-B.

Respondents are physicians who claim a right to prescribe lethal medication for mentally competent, terminally-ill patients who are suffering great pain and who desire doctor's help in taking their own lives, but are deterred from doing so because of the New York Act. They contend that this is no different from permitting a person to refuse life sustaining medical treatment and hence, the Act is discriminatory.

This plea was not accepted by the US Supreme Court. The Equal Protection Clause states that no State shall 'deny to any person within its jurisdiction the equal protection of the laws'. This provision creates no substantive rights. It embodies a general rule that the State must treat like cases alike but may however, treat unlike cases differently. Everyone, regardless of physical condition is entitled, if competent, to refuse unwanted life-saving medical treatment, but no one is permitted to assist a suicide. The "distinction between assisted suicide and withdrawing life-sustaining treatment", a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical. It is certainly rational'. 'The distinction comports with fundamental legal principles of causation and intent. First, when a patient refuses life-

sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication. (Death which occurs after the removal of life-sustaining systems is from natural causes). (When a life-sustaining treatment is declined, the patient dies primarily because of an underlying fatal disease). In the debates before the Sub-Committee of the House, it was pointed out that withdrawal of treatment and assisted suicide are different. ‘Furthermore, a physician who withdraws or honours a patient’s refusal to begin life sustaining medical treatment, purposefully intends or may so intend, only to respect his patient’s wishes and “to cease doing useless and futile or degrading things to the patient when (the patient) no longer stands to benefit from them.... The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient’s death, but the physician’s purpose and intent is, or may be, only to ease his patient’s pain.” A doctor who assists a suicide, however, “most, necessarily and indubitably, intends primarily that the patient be made dead”. Similarly, a patient who commits suicide with a doctor’s aid necessarily has the specific intent to end his or her life, while a patient who refuses or discontinues treatment might not.... See e.g. Matter of Conroy, (1985) 98 N.J. 321 (at 351), (patients who refuse life sustaining treatment ‘may not harbor a specific intent to die’ and may instead ‘fervently wish to live, but to do so free of unwanted medical technology, surgery or drugs).

“..., it is not surprising that many Courts, including New York Courts, have carefully distinguished refusing life-sustaining treatment from suicide. See e.g. Fosmire vs. Nicolean, 75 NY 2d 218 (Merely declining medical ..... care is not considered a suicidal act’). In fact, the first State

Court decision explicitly to authorize withdrawing life-sustaining treatment noted the ‘real distinction between self infliction of deadly harm and a self determination against artificial life support. (In re Quinlan 70 NJ 10: 355 A.2d. 647...) And recently, the Michigan Supreme Court also rejected the argument that the distinction ‘between acts that artificially sustain life and acts that artificially curtail life’ is merely ‘a distinction without constitutional significance – a meaningless exercise in semantic gymnastics’, insisting that ‘the Cruzan majority disagreed and so do we. (“Kevorkian: 447 Mich at 471)”

Similarly, the overwhelming majority of State legislatures have drawn a clear line between assisting suicide and withdrawing or permitting the refusal of unwanted life-saving medical treatment by prohibiting the former and permitting the latter. Washington vs. Glucksberg (1997) 117 S.Ct 2258, and ‘nearly all States expressly disapprove of suicide and assisted suicide either in statutes dealing with durable powers of attorney in health care situations or in ‘living will’ statutes. Kevorkian 447 Mich at 478-479... Thus, even as the States move to protect and promote patient’s dignity at the end of life, they remain opposed to physician assisted suicide’.

The Court then said that the New York State enacted the current assisted suicide statutes in 1965 prohibiting assisted suicide. Since then, New York has acted several times to protect patient’s common law-rights to refuse treatment. Act of Aug 7, 1987, Ch 818, ss. 1.; 1987 NY Laws 3140 (‘Do not Resuscitate Orders’)(Codified as amended at NY Pub Health Law, see 2960-2979 (McKinney 1994 U Supp. 1997); Act of July 22, 1990, Ch 752, sec 2, 1990 NY Law, 3547 (Health Care Agents and Proxies)(Codified as amended NY Pub. Health Law, paras 2980-2994 (McKinney 1994 &

Suppl 1997). In so doing, however, the State has neither endorsed a general right to ‘hasten death’ nor approved physician assisted suicide. Quite the opposite: The State has reaffirmed the line between ‘killing’ and ‘letting die’. See NY Pub. Health Law Art 2989 (3)(McKinney 1994) (“This article is not intended to permit or promote suicide, assisted suicide or euthanasia”) .... More recently the New York Task Force on ‘life and the law’, studied assisted suicide and euthanasia and, in 1994, unanimously recommended against legalization.... In the Task Force’s view, ‘allowing decisions to forego life sustaining treatment and allowing assisted suicide or euthanasia have radically different consequences and meanings for public policy.’”

‘This Court has also recognized, at least implicitly, the distinction between letting a patient die and making that patient die. In Cruzan vs. Director, MO, Deptt. Of Health, 497 US 261, 278 p 1990), we concluded that ‘the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions and we assumed the existence of such a right for purposes of that case. But our assumption of a right to refuse treatment was grounded not, as the Court of Appeals supposed, on the proposition that patients have a general and obtrusive (right to hasten death), but on well-established, traditional rights to bodily integrity and freedom from unwanted touching.... In fact, we observed that ‘the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide. Cruzan therefore provided no support for the notion that refusing life sustaining medical treatment is ‘nothing more nor less than suicide’.

The Court declared that they were disagreeing with the respondent's claim that the distinction between refusing life saving medical treatment and assisted suicide is 'arbitrary' and 'irrational'. Granted, in some cases, the line between the two may not be clear, but certainly is not required, even if it were possible. Logic and contemporary practice support New York's judgment that the two acts are different and New York may therefore, consistent with the Constitution, treat them differently. By permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a long standing and rational distinction.

New York's reasons for recognizing and acting on this distinction – including prohibitory intentional killing and preserving life; preventing suicide; maintaining physician's role as their patient's healers; protecting vulnerable people from indifference, prejudice and psychological and financial pressure to end their lives' and avoiding a possible slide towards euthanasia – are discussed in greater detail in the judgment in Washington vs. Glucksberg, ante. These valid and important public interests easily satisfy the constitutional requirement that a legislative clarification bear a rational relation to some legitimate end.”

For the above reasons, the Supreme Court reversed the Court of Appeal and upheld the New York ban against assisted suicide.

- 4) Gonzales, Att. Gen et al v. Oregon et al: US (SC) (d. 17.1.2006)

The Supreme Court, in this case, upheld the Oregon law of 1994 on assisted suicide not on merits but on the question of non-repugnancy with Federal Law of 1970.

The Oregon Death With Dignity Act, 1994 exempts from civil or criminal liability state-licensed physicians who, in compliance with the said Act's specific safeguards, dispense or prescribe a lethal dose of drugs upon the request of a terminally ill-patient. In 2001, the Attorney General of US issued an Interpretative Rule to address the implementation and enforcement of the Controlled Substances Act, 1970 with respect to the Oregon Act of 1994, declaring that using controlled substances to 'assist suicide' is not a legitimate medical practice and that dispensing or prescribing them for this purpose is unlawful under the 1970 Act.

The State of Oregon, a physician, a pharmacist and some terminally ill State residents challenge the Rule made by the AG. The Ninth Circuit, on appeal, invalidated the Rule, reasoning that by making a medical procedure authorized under Oregon law a 'federal offence', it altered the balance between the States and the Federal Government without the requisite clear statement that the 1970 Act authorized the action; and in the alternative, that the Rule could not be squared with the plain language of the 1970 Act', which targets only conventional drug abuse and excludes the Attorney General from medical policy decisions.

It may be noted that the 1970 Federal Act's main objectives of controlling drug abuse and controlling legitimate and illegitimate traffic in controlled substances, criminalizes, inter alia, the unauthorized distribution and dispensation of substances classified in any of its five schedules. The Attorney General may add, remove, or reschedule substances only after

making particular findings, and on scientific and medical matters, he must accept the findings of the Secretary of Health and Human Services (Secretary). These proceedings must be on the record after an opportunity for comment. The dispute here involves controlled substances listed in Sch. II, which are generally available only by written prescription (21 USC sec. 829 (a)). A 1971 regulation promulgated by the Attorney General of US requires that such prescriptions be used “for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice” 21 CFR, sec. 1306.04. To prevent diversion of controlled substances, the 1970 Act regulates the activity of physicians, who must register in accordance with rules and regulations promulgated by the Attorney General. He may deny, suspend, or revoke a registration that, (as relevant here), would be ‘inconsistent with the public interest’. (21 USC sec. 824(a)(4) & 822(a)(2)). In determining consistency with the public interest, he must consider five factors, including the States recommendations, compliance with State, federal and local law regarding controlled substances, and ‘public health and safety’ (sec. 823(f)). The 1970 Act explicitly contemplates a role for the States in regulating controlled substances (sec. 903). So held the 9<sup>th</sup> Circuit.

The US Supreme Court (majority) held, in the appeal by the Attorney General US, that the 1970 Act does not allow the Attorney General to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide under State law permitting the procedure. The Appeal was dismissed.

### Some Legislations in US

(1) The Patient Self Determination Act, 1990: (42 USC 1395 cc(a))

Soon after Cruzan, the Federal Legislature of US passed the Patient Self Determination Act, 1990 which came into force w.e.f. 1<sup>st</sup> December, 1991. It applies to hospitals, nursing facilities, hospices, and health-care providers receiving funds under the Plan. It requires that these institutions give patients information concerning their legal rights to make decisions about the medical care and treatment they are about to receive. (This Act was part of the Omnibus Budget Reconciliation Act, 1990).

Under sec. 1902(2)(w)(1) of the Act (see sec 1902), the above institutions have:

- (1) (A) to provide to each adult individual receiving medical care by or through the provider or organization, written information, concerning -
- (i) an individual's rights under State Law (whether statutory or as recognized by the Courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives) (as defined in paragraph (3), and
  - (ii) the provider's or organization's written policies respecting the implementation of such rights;
- (B) to document in the individual's medical record whether or not the individual has executed an advance directive;

- (C) not to condition the provisions of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
- (D) to ensure compliance with requirements of State law (whether statutory or as recognized by the Courts of the State) respecting advance directives; and
- (E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subpara (C) (above) shall not be considered as requiring the provisions of care which conflicts with an advance directive.

- (2) The written information described in para 1(A) shall be provided to an adult individual –
  - (A) in the case of a hospital, at the time of the individual's admission as in patient,
  - (B) in the case of a nursing facility, at the time of ....
  - (C) in the case of a provider of home health, at the time of ....
  - (D) in the case of a hospice program, at the time of ....
  - (E) in the case of a health monitor program, at the time of....
- (3) Nothing in this section shall be constituted to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of

such provider which, as a matter of conscience, cannot implement an advance directive.

- (4) In this subsection, the term ‘advance directive’ means a written instruction, such as a living will or durable power of attorney for health care, recognized under State Law (whether statutory or as recognised by the Courts of the State) and relating to the provisions of such care when the individual is incapacitated.

The Act also provides for ‘information respecting advance directives, effective data, public education campaign etc.’

Thereafter, certain Regulations called, ‘The Federal Patient Self-Regulation Act, Final Regulations’ have been passed.

- (2) National Pain Care Policy Act, 2005 (US) (introduced in House (Federal))

(<http://thomas10a.gov/cgi-him/query/F?c109:1:temp/nc109nx4ks:e1070>)

Section 2 states that not later than 30.6.2006, the President shall convene a conference to be known as the ‘White House Conference on Pain Care) – The purpose of the Conference shall be to

- (1) increase the recognition of pain as a significant public health problem in US;
- (2) assess the adequacy of diagnosis and treatment for primary and secondary pain including acute, chronic, intractable and end-of-life pain;

- (3) identify barriers to appropriate pain care including –
  - (A) lack of understanding and education among employees, patients, providers, Regulators and third party payers;
  - (B) barriers to access to care at the primary, specialty, and tertiary care levels; and
  - (C) gaps in basic and clinical research on the symptoms and causes of, and potential treatments to improve, pain care; and
  - (D) establish an agenda for action in both public and private sectors that will reduce such barriers and significantly improve the state of pain-care research, education and clinical care in US by 2010.

Section 3 proposes establishing a National Centre for Pain and Palliative Research; section 4 refers to Pain Care Education and Training; section 5 to Public Awareness Campaign on pain management, section 6 to Pain Care initiative in military health Care facilities; section 7 to pain care standards in Tricare Plans; section 9 to Annual Report on Medicare Expenditure for pain care services, section 10 to pain care initiative in veteran's health care facilities.

The Act requires the Director of National Health Institute to establish at least 6 regional pain research centres. It permits Secretary to award grants, cooperative agreements, and contracts to public and private entities, to educate and train health professionals in pain and palliative care. It directs the Secretary to implement a national campaign to inform the public on responsible pain management, related symptoms management and

palliative care. It requires the Secretaries of Defence, Homeland Security, and Health and Human Services to develop and implement a pain-care palliative initiative in all health care facilities of the uniformed services. It requires Medicare Advantage Organisation to meet certain pain care standards. It requires the Secretary of Veterans Affairs to develop and implement a pain-care initiative in all health care facilities of the Deptt. of Veterans Affairs.

(B) States in US

In the States in US, an 'advance directive' means a document which a person must fill stating in advance what kind of treatment he wants or does not want under special, or serious medical conditions. Such a directive allows a person to state his choices of health-care, or to name someone to make those choices for him if he is unable to do so. It enables the person to make decisions about future medical treatment, to say yes to treatment he wants or no to treatment he does not want. An advance directive can limit life-prolonging measures when an event occurs from which there is little or no chance of recovery.

California

In California, there are two types of instruments: (see <http://www.network17.org/consumerarticles/ptselfd4.htm>). The first one refers to below delegates decision making to another while the second one deals with the decision of the patient himself.

(i) Durable power of attorney for Health Care:

In US, this is stated to be the best legal instrument to ensure that one's wishes will be followed. It is a signed, dated and witnessed paper naming another person as one's agent or proxy to make 'medical decisions' if one becomes unable to make them for oneself. This might be one's husband or wife or son or daughter or a close friend.

An agent has to be chosen with care. He should be somebody with whom one is comfortable to talk to, or is known closely, somebody with whom one has discussed his views on these matters. He should be someone who is available when needed. He should be instructed about any treatment one wishes to eliminate or avoid.

(ii) Natural Death Act declaration:

The type of living will recognized in California is called the Natural Death Act 1977 Declaration. A person completes and signs the form and that declaration tells the doctor and the staff that the person does not want any treatment that would prolong his dying. It tells the doctor to stop (or not to start) any life sustaining treatment if the person is terminally ill or permanently unconscious.

If a person is not comfortable with a Natural Death Act Declaration, he can fill out a non-statutory living will to state when he would or would not want to be treated.

A person is not limited to one or the other of these forms; he may execute both of them if he wishes. Once that has been done, one may change them at any time by informing all the appropriate people that there is a change in one's mind. The old copies can be destroyed.

The consent must be informed consent and hence following are important issues one has to consider. For example in the case of dialysis, one has to consider the following aspects:

- (1) What are the most important goals of dialysis treatment?
- (2) Would I want dialysis to continue if it just seemed delaying death?
- (3) Under what circumstances would I want it to be stopped?
- (4) How much treatment would I want if there were little chance of recovery from a serious side-effect?
- (5) Would I want dialysis to continue if I were permanently conscious?

Some other issues which one should think in making decisions on treatment are:

- (1) Relief of pain
- (2) Ability to think and communicate
- (3) Financial costs
- (4) Suffering and anxiety to others
- (5) Control of bodily functions (bowel, bladder etc.)
- (6) Ability to move about
- (7) Religious needs
- (8) Dependency

Some suggestions which patients may give to their family or friends are as follows:

- (1) In case of doubt, err on the side of life.
- (2) I want those treatments that offer reasonable hope to restore me to a condition that my loved ones think I would find acceptable.
- (3) I do not want treatment that might postpone death but probably would not restore me to a quality of life that I find acceptable.
- (4) I do/do not want a treatment if there is some small, remote chance that it might help me.
- (5) I want treatment decisions made with a view to my overall condition and the treatments' ability to improve this.
- (6) I want sufficient pain medication to keep me free of pain even if the dosage may shorten my life.
- (7) I want the cost of treatment and its financial impact on my family/community to be considered in making decisions.
- (8) If I lose consciousness with no reasonable hope of ever regaining it, I want all treatment stopped (including food and fluids).
- (9) I want my loved ones/professionals to make decisions about my care the way they think I would make them, were I able.

In California, an Advance Directive in the form of a Durable Power of Attorney for Health Care is available from the California Medical Association PO Box 7600, San Francisco or phone 415-882-5175 etc. The

form has to be witnessed by two persons. One of them has to be someone who is not related and who is not named in any testamentary document as a person who will inherit property of the patient. A copy has to be given to the proxy/agent, to your doctor and your dialysis head-nurse or administrator. Original will remain with the patient in a safe place.

If one does not want to approve another to make decisions for him, he can sign a National Death Act Declaration to direct that life-saving measure may not be used if certain situations arise.

#### Other States in US:

Living wills are recognized bylaw in 40 States in US. For example in Arkansas, it is governed by the ‘Rights of Terminally Ill or Permanently Unconscious Act. (ACA, 20-17-201). One must be 18 years or older to execute a will. One must sign the document or if physically unable, direct another to sign. Two witnesses are necessary.

#### South Carolina:

##### Living will under Death with Dignity Act

(<http://www.state.sc.us/dmh/804-97.htm>)

The Death with Dignity Act authorizes competent adults to express their wishes regarding the use or withholding of life-sustaining procedures, including artificial nutrition and hydration, in the event they are incapacitated or otherwise unable to express their desires. The Act creates a statutory form for this purpose titled ‘Declaration of a Desire for Natural Death’. This document is commonly referred as a living will. (see App. 1 of the Act)

(1) Health Care Power of Attorney:

Sections within South Carolina Probate Code authorizes competent adults to designate another person to make decisions on their behalf about their medical care in the event they become incapacitated. The Code creates a statutory form for this purpose entitled 'Health Care Power of Attorney'. The Department has developed a form entitled 'Statement of Desires Regarding Mental Health Treatment and Care' for use as an addendum to the statutory 'Health Care Power of Attorney' form (App 2, 3)

(2) A "Do not Resuscitate Order" is a written physician's order not to begin the otherwise automatic initiation of Cardio-pulmonary resuscitation, in the event the patient suffers cardiac or respiratory arrest. It is appropriate in situations involving a patient with a terminal condition or a patient in a state of permanent unconsciousness, and is generally entered with the consent of the patient or the patient's substitute decision maker, or in circumstances where resuscitative efforts are inappropriate or medically futile. Although the entry of a 'Do Not Resuscitate Order' involves advance planning for the withholding of a specific health-care procedures, and frequently involves consultation with the patient, it is not considered an Advance Directive for purposes of the Patient Self Determination Act or this Directive. It is only one means of effecting a patient's Advance Directive for the withholding of life sustaining procedures when the conditions set forth in the Advance Directive are met.

(C) US State Court judgments:

There are a very large number of Judgments of the US Courts and statutes of the various States but we do not propose to refer to them. We

have already referred to the leading judgments of the US Supreme Court. Further, we are of the view that the ‘substituted judgment’ (of surrogate) principles which are evolved in US are not suitable for India and, in fact, the House of Lords in NHS Trust vs. Bland did not think it fit to introduce those principles into English law. For the same reason, we do not propose to refer to the case law on ‘substituted judgments’ of the US State Courts.

We shall next move on to consider the position in Canada, Australia, New Zealand.

## Chapter –VI

### Legal position in Canada, Australia, New Zealand and

### South Africa

In this chapter, we shall refer to the case law and connected statutes on the subject of withholding or withdrawing medical treatment to terminally ill patients in Canada, Australia, New Zealand and South Africa.

#### Canada

(1) Malette vs. Schulman: (1990) 72 O.R. (2d) 417(CA): 1991(2)Med LR. 162.

In this case, a 57 years old woman who was seriously injured in a car accident was taken to the hospital and she was unconscious. A nurse discovered in the woman's handbag, a card signed by the woman identifying her as a Jehovah's Witness and requesting that no blood-transfusions be given to her under any circumstances, that she fully realized the implications of that position but did not object to the case of non-blood alternatives.

The doctor was informed of the contents of the card but he personally administered blood transfusion to the woman as he was of the opinion that it was necessary to replace the blood that was lost and her life had to be saved. The woman made 'a very good recovery from her injuries'. She was discharged from hospital after 6 weeks. She then sued the doctor for negligence, assault, battery and religious discrimination.

The trial judge Donnelly J accepted the plea of battery only and awarded damages of \$20,000. This was affirmed by the Court of Appeal. The case demonstrates that doctors must respect their patient's wishes provided that the patients were in a fit state to make it plain or indicate in advance as to what treatment they do not want. Doctors cannot substitute their decision from a validly made decision of the patient.

(2) Nancy B vs. Hotel-Dieu de Quebec: (1992) 86 DLR (4<sup>th</sup>) 385 = 1992 DLR Lexis 1762 decided by the Quebec Supreme Court. (Dufour J)

The plaintiff, aged 25, suffered for two and a half years from Guillian – Barre Syndrome, an incurable neurological disorder that left her incapable of movement. She could breathe only with the assistance of a respirator. With it, of course, she could live a longer time, but without it, her life would be shorter. Her intellectual capacity and mental competence were unaffected. She wanted discontinuance of the treatment. To establish her right to refuse further treatment, (including the continued use of the respirator), she commenced an action for an injunction against the hospital and as also her physician to require them to comply with her decision for stopping the respiratory support. The hospital entered appearance but did not contest her claim. Her physician did not appear. The Judge, of his own motion, made the Attorney General of Quebec a party. All other parties were represented at the hearing.

The Court held that the plaintiff was entitled to the injunction. Permission should be given to her physician to cease treatment with the

respirator at a time chosen by the plaintiff. The physician was entitled to the assistance of the hospital.

The Court referred to the Articles of Civil Code and certain sections of the Criminal Code.

Use of a respirator to maintain life is a 'treatment' and hence is something within the individual's control. As per Arts. 19, 19(1) of the Civil Code of Lower Canada, the body of every person is physically inviolable except with the person's consent or legal authority, and no one need submit to any treatment, examination or other intervention (against his or her will). By virtue of Ethics of Physicians RRQ, C (1981, C.M-9, r 4 Arts 2.02.01, 2.03.02, 2.03.28), a person is entitled to autonomy in respect of his or her body. No treatment may be given to a person except with that person's consent or that of someone authorized by law. A physician is obliged under the Public Health Protection Act, R.S.Q 1977 (C. p 35) to protect the health and well-being of an individual, but must obtain the free and informed consent of the patient to any treatment.

It was held that the right of the individual to refuse treatment is almost absolute, being subject only to a corresponding right of others. The individual may not threaten the life or health of others. The individual has the right to determine whether or not to accept treatment; and putting and keeping someone on a respirator without an informed consent is an improper interference with the person. The Criminal Procedure Code (R.S.C. 1985, C. C-46) does not affect the case. If treatment is withdrawn, the plaintiff's death would be natural and would not involve homicide or suicide.

The Court referred, among other decisions, to Cruzan decided by the US Supreme Court.

It may here be useful to refer to some of the statutory provisions of Lower Canada referred to in the judgment.

Civil Code:

Art 18 of the Civil Code states that ‘every human being possesses juridical personality. Whether citizen or alien, he has the full enjoyment of civil rights, except as otherwise expressly provided by law’. Art 19 states that the ‘human person is inviolable and no one may cause harm to the person of another, without his consent or without being authorized by law to do so. Art 19.1 states that ‘no person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent. Where the person concerned is unable to consent to or refuse care, a person authorized by law or by mandate shall replace him. (Art 19.1 was added on 22<sup>nd</sup> June, 1989).

Even before Art 19.1 was inserted, one could infer from sec 42 of the Public Health Protection Act, 1977 (RSQ 1977C p.35) that an institution or a physician had to obtain the consent of the person whose life was in danger, before providing care or treatment.

The Code of Ethics of Physician, RRQ. 1981, C.M-9, r 4 is clear in this regard. One also sees that the Code gives precedence to the patient’s freedom of choice in any decision concerning himself over the duty of the physician to protect his health and well-being.

Ethics: Rule 4, paras: 2.02.01. “The physician must not, by any means, either directly or indirectly, interfere with the patient’s freedom of choice of a physician.”

“2.03.28 Except in an emergency, a physician must, before undertaking an investigation, treatment or research, obtain informed consent from the patient or his representative or any person whose consent may be required by law.

2.03.29 A physician must ensure that the patient or his representative or the person whose consent may be required by law, receive suitable explanation on the nature, purpose and possible consequences of the investigation, treatment or research which the physician prepares to make.”

In Art 19.1 of the Civil Code, the legislature has made no distinction between beneficial and non-beneficial care.

After referring to these provisions, the Judge in Nancy said that using a respirator was part of ‘medical treatment’. Putting a person on a respirator and constantly keeping her on it without her consent, surely constitutes intrusion and interference which violates the person of Nancy B. She can require the respiratory system to be removed.

The Judge observed: “In any event, declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.”

The Judge referred to sec 217 of the Criminal Code, which says:

“217. Every one who undertakes to do an act is under a legal duty to do it if any omission to do the act is or may be dangerous to life”.

In respect of sec. 217, (formerly sec 199 of the previous Criminal Code), the Law Reform Commission of Canada, in its Working Paper 28 (Euthanasia, Aiding Suicide and Cessation of Treatment) (1982) (p 17) had stated:

“Section 199 of the Criminal Code, read in isolation, seems to imply that a physician who has undertaken treatment is not permitted to terminate it if this involves a risk to the life of the patient. If this were the case, the law would require the use of aggressive and useless therapy. It would have the effect, in many cases, of causing doctors to hesitate seriously before undertaking treatment, for fear of not being permitted to terminate it later, when it no longer appears to be useful. If this were the actual implication of the rules, then the rule would be absurd and would have disastrous effects on medical practice.”

It should not be forgotten that sec 217 follows sec 216 which reads:

“Section 216. Duty of persons undertaking acts dangerous to life: Everyone who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in case of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.”

Section 217 which comes immediately after sec. 216 cannot be read independently of sec 216 which requires that a physician act with reasonable knowledge, skill and care when he undertakes to administer surgical or medical treatment to another person or does any other lawful act that may endanger the life of another person, sec 217 logically follows from sec 216.

One must read sec 217 in conjunction with sec 45 and 219 of the same Code:

“Section 45: Surgical Operations: Everyone is protected from criminal responsibility for performing a surgical operation on any person for the benefit of that person if:

- (a) the operation is performed with reasonable care and skill;
- (b) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.”

Section 219: Criminal negligence: (1) Everyone is criminally negligent who:

- (a) in doing anything, or
- (b) in omitting to do anything that it is his duty to do; shows wanton or reckless disregard for the lives or safety of other persons.

Definition of duty: (2) For the purposes of this section, ‘duty’ means a duty imposed by law.”

In the above section 219, the notion of conduct which shows wanton or reckless disregard is introduced.

The Judge asked the question: ‘Can the conduct of a physician who stops the respiratory support treatment of his patient – at the freely given and informed request of the patient, and so that nature may take its course, be characterized as unreasonable? Or does conduct denote wanton and reckless disregard?’

The Judge answered: ‘I do not believe so’.

He then referred to ss 222 to 241 of the Criminal Code which deals with a different form of homicide and he stated that what he had just reviewed was sufficient to conclude that the person who would have to stop Nancy B’s respiratory support treatment in order to allow nature to take its course, would not in any manner commit the crimes prohibited by these sections. The same applied to sec 241, aiding suicide.

He adds, however, that homicide and suicide are not natural deaths, whereas in the present case, if the plaintiff’s death takes place after the respiratory support treatment is stopped at her request, it could be the result of nature taking its own course.

The Judge finally permitted the plaintiff’s attending physician, to stop the respiratory support treatment being given to the patient, when she so desires; her consent must however be checked once again before any act in this regard is done. He also permitted the physician to request from the defendant hospital the necessary assistance in circumstances such as here, so that everything can take place in a manner respecting the dignity of the plaintiff.

3) Ciarlariello vs. Schacter: 1993(2) SCR 119 (La Forest, Sopinka, Cory, McLachlin, Iacobucci JJ)

This is a judgment of the Canadian Supreme Court and deals with the validity of consent given by patients during the course of the treatment.

Mrs. C was diagnosed with a suspected aneurism. Her Neurologist explained through an interpreter both the nature of the angiogram (X-raying of a dye, leading to the brain) and the risks involved. The first procedure was performed by Dr. Mrs Keller, an experienced radiologist. The patient was again explained the procedure through an interpreter. She appeared to understand and gave her consent. Dr. Keller had some misgivings about the patient's complete comprehension. She therefore destroyed the original consent form and insisted that the patient be sent back to her own hospital so that she could talk to her family about her test. She later returned to Dr. Mrs. Keller herself with a consent form signed by her daughter.

The first cerebral angiogram failed to demonstrate a definite aneurism and it was decided that a second was needed. Before that could be done, a 're-bleed' of the aneurism was diagnosed. This increased the risk of morbidity. The patient consented to a second cerebral angiogram. Dr. Greco, also an experienced radiologist, explained the nature of the tests and risks and the patient appeared to understand and consented to the procedure.

During the test, the patient experienced discomfort when hyperventilated and, when she calmed down, she told the doctor to stop the test. The doctors determined that any symptoms she experienced were caused by tetany. The patient, when calm, instructed the doctors to finish the test after they informed her that it would take another five minutes to

complete. Dr. Keller, administered the final injection. The patient suffered an immediate reaction to the injection of the dye which rendered her a quadriplegic. Dr. Keller testified that such a reaction was extremely rare and that never before or since, had she seen such a reaction.

The patient brought an action against the respondent physicians. The patient died subsequent to the trial and the appellants carried on the action as her legal representatives. The action and the appeal were dismissed.

The point in issue was the nature and extent of the duty of disclosure owed by a doctor to a patient where the patient withdraws the consent given to a medical procedure during the course of that procedure.

It was held by Cory J, speaking for the Canadian Supreme Court, that there was a sound factual basis for concluding that the patient consented to the continuation of the angiogram and that she was giving consent to continuing the procedure. There was neither fraud nor misinformation in obtaining her consent. The procedure was the one anticipated and was identical to one performed a week earlier.

An objective approach should be taken in deciding whether a risk was material and, therefore, one which should be explained to the patient. The crucial question in determining the issue was whether a reasonable person in the patient's position would want to know of the risk. The doctors involved conducted themselves in an exemplary manner. All the possible risks that could arise from the procedure were fully explained on several occasions to both the patient and her daughter.

Whether or not there has been a withdrawal of consent by a patient is a question of fact. The words used by a patient may be ambiguous. Even if

they are apparently clear, the circumstances under which they are spoken may render them ambiguous. On some occasions, the doctors conducting the process may reasonably take the words spoken by the patient to be an expression of pain rather than a withdrawal of consent.

If there is any question of a patient's withdrawal of consent, the doctor must ascertain whether the consent has in fact been withdrawn. Every patient's right to bodily integrity encompasses the right to determine what medical procedure will be accepted and the extent to which they will be accepted. The right to decide what is to be done to one's body includes the right to be free from medical treatment to which the individual does not consent. The requirement that disclosure be made to the patient is based on this concept of individual autonomy.

If during the course of a medical procedure a patient withdraws the consent, then the doctors must halt the process unless the medical evidence suggested that terminating the process would be either life-threatening or pose immediate and serious problems to the health of the patient.

The question as to whether or not a consent given has been withdrawn during the course of a procedure will depend upon the circumstances of each case and may require the trial judge to make difficult findings of fact. Expert medical evidence, while relevant, will not necessarily be determinative of the issue. Indeed, in cases such as these, where the patient must be conscious and cooperative in order for the procedure to be performed, it may well be beyond doubt that the patient was capable of withdrawing consent. The fact that the patient had withdrawn consent at one stage was not in issue here but she later wanted the test to be continued.

The appropriate approach is to focus, in each case, on what the patient would like to know concerning the continuation of the process, once consent has been withdrawn. Looking at it objectively, a patient would want to know whether there had been any significant change in the risks involved or in the need for the continuation of this process which had become apparent during the course of the procedure. In addition, the patient would want to know if there had been a material change in circumstances which could alter the patient's assessment of the costs or benefit of continuing the procedure. Changes may arise during the course of the procedure which are not at all relevant to the issue of consent. Yet, the crucial question would always be whether the patient would want to have the information pertaining to those changes in order to decide whether to continue treatment. The patient here was capable of giving her consent to the continuation of the procedure based on the earlier disclosures and did so.

The doctor must bear the burden of showing that the patient understood the explanation and instructions, given. The conclusion that the patient here understood and had given valid consent to continue the procedure, notwithstanding the absence of an interpreter, could be drawn from her demonstrated ability to comprehend the language adequately. There was complete and proper disclosure made by the respondents of all the risk involved in the procedure. The appellant's action in negligence must fail.

Cory J, after referring to the principles governing 'liability for battering' and considered the plea of negligence in the light of 'standard of disclosure' expected and the consequences of withdrawal of consent. He

quoted Robins JA in Fleming vs. Reid (1991) 4.C.R.(3d)74(CA) and said that the 'right to determine what shall or shall not be done to one's body and to be free from non-consensual medical treatment, is a right deep-rooted in our common law. This right underlines the doctrine of informed consent. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination. It is the patient, not the doctor, who ultimately must decide if treatment or any treatment is to be administered.

On facts, it was held that the patient consented to both the angiograms and to the continuation of the second one. There was no fraud in representation. The action must fail.

- 4) Rodriguez vs. The Attorney General of Canada and Others: (1993)(3) SCR 519 (Lamer CJ, La Forest, L'Heureux – Dube, Sopinka, Gonthier, Cory, McLachlin, Iacobucci and Major JJ)

The case is very important and deals with a number of legal principles. It dealt with the challenge by a patient to a section in the Criminal Code which prohibited 'assisted-suicide'.

The appellant in the case was 42 years old and was suffering from amyotrophic lateral sclerosis. Her condition was rapidly deteriorating and she would soon lose her ability to swallow, speak, walk and move her body without assistance. Thereafter she will lose the capacity to breathe without a respirator, to eat without a gastronomy and will eventually become confined to bed. Her life expectancy was between 2 to 14 months.

The appellant did not wish to die so long as she still had the capacity to enjoy life, but wished that a qualified physician be allowed to set up

technological means by which she might, when she will be no longer able to enjoy life, by her own hand, at the time of her choosing, end her life. She wanted to be assisted in suicide.

She applied to the Supreme Court of British Columbia for a declaration that sec 241(b) of the Criminal Code, which prohibits the giving of assistance to commit suicide, be declared invalid on the ground that it violates her rights under ss 7, 12 and 15(1) of the Charter, and is therefore, to that extent it precludes a terminally ill-person from committing ‘physician-assisted’ suicide, of no force and effect by virtue of sec 52(1) of the Constitution Act, 1982. (In Canada, as stated in judgment of Sopinka J, attempt to commit suicide was not unlawful but abetment of suicide was an offence.)

Sec. 241 of the Criminal Code (RSC 1985, c. C-46) reads as follows:

“sec. 241: Every one who

- (a) counsels a person to commit suicide, or
- (b) aids or abets a person to commit suicide, whether suicide ensues or not,

is guilty of indictable offence and liable to imprisonment for a term not exceeding fourteen years”

The plaintiff contended sec. 241(b) was invalid.

The Court dismissed the appellant’s application by majority (there was dissent by Lamer CJ, L’Heureux Dube, Cory and McLachlin JJ) and the validity of sec 241(b) was upheld.

The relevant provisions of the Canadian Charter of Rights and Freedoms are as follows:

“Article 1: The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Article 7: Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Article 12: Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

Article 15 (1): Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without dissemination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.”

We shall refer to the majority judgment, which upheld the provisions that made assisted suicide, an offence.

Sopinka J, speaking for the majority, observed that the ‘right to security of person’, under Art 7 of the Charter cannot encompass a right to take action that will end one’s life in as much as security of the person is intrinsically concerned with the well-being of the living person. This is based on the notion generally held and deeply rooted in our society that human life is sacred and inviolable (which terms are used in the non-

religious sense described by Dworkin (in ‘Life’s Dominion: An argument about Abortion, Euthanasia, and Individual Freedom (1993) ) to mean that human life is seen to have a deep intrinsic value of its own. As members of a society based on respect for the intrinsic value of human life and on the inherent dignity of every human being, can we incorporate, he asked, within the Constitution which embodies our most fundamental values, a right to terminate one’s own life in any circumstances? This raises issues of sanctity of life which includes notions of quality of life.

Sanctity of life has been understood as excluding freedom of choice in the self-infliction of death and certainly in the involvement of others in carrying out that choice.

It was argued that for the terminally ill, the choice was one of time and the manner of death rather than death itself since the latter was inevitable. Sopinka J disagreed stating that “it is one of choosing death instead of allowing natural forces to run their course. The time and precise manner of death remains unknown until death actually occurs. There can be no certainty in forecasting the precise circumstances of death. Death is, for all mortals, inevitable. Even when death appears imminent, seeking to control the manner and timing of one’s death constitutes a conscious choice of death over life. It follows that life, as a value, is engaged even in the case of the terminally ill who seek to choose death over life. Indeed, it has been abundantly pointed out that such persons are particularly vulnerable as to their life and will to live and great concern has been expressed as to their adequate protection, ....”

The Canadian case law leads to the conclusion that state interference with bodily integrity and serious state-imposed psychological stress, at least in the criminal law context, constitute a breach of the security of the person.

The learned Judge said:

“It is not necessary to determine whether the right extends further, to protect other interests central to personal autonomy, such as right to privacy, or interests unrelated to criminal justice. Although this interference with physical and emotional integrity is sufficient in itself to trigger a review of sec 251 against the principles of fundamental justice, the operation of the decision-making mechanism set out in sec 251 creates additional glaring breaches of security of the person.” (There is no reference to language of sec. 251 in any part of the judgment.)

The judgments of the Canadian Supreme Court can be seen to encompass a notion of personal autonomy involving, at the very least, control over one’s body integrity free from State interference and freed from State imposed psychological and emotional stress.

The learned Judge stated:

“There is no question, then, that personal autonomy, at least with respect to the right to make choices concerning one’s body, control over one’s physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these.”

It was further observed:

“The effect of the prohibition in sec. 241(b) is to prevent the appellant from having assistance to commit suicide when she is no longer able to do so on her own. She fears that she will be required to live until the deterioration from her disease is such that she will die as a result of choking, suffocation or pneumonia caused by aspiration of food or secretions. She will be totally dependent upon machines to perform her bodily functions and completely dependent upon others. Throughout this time, she will remain mentally competent and able to appreciate all that is happening to her. Although palliative-care may be available to ease the pain and other physical discomfort which she will experience, the appellant fears the sedating effect of such drugs and argues in any event, that they will not prevent the psychological and emotional distress which will result from being in a situation of utter dependence and loss of dignity. That there is a right to choose how one’s body will be dealt with, even in the context of beneficial medical treatment, has long been recognized by the common law. To impose medical treatment on one who refuses it constitutes battering and our common law has recognized the right to demand that medical treatment which would extend life be withheld or withdrawn. In my view, these considerations lead to the conclusion that the prohibition in sec 241(b), no doubt, deprives the appellant of autonomy over her person and causes her physical pain and psychological stress in a manner which infringes on the security of her person.”

But does this lead to any deprivation thereof that is not in accordance with the principles of fundamental justice?

In approaching this step, the caveat of Prof L Tribe, in his American Constitutional Law (2<sup>nd</sup> Ed, 1988, p 1370-71) is relevant:

“The right of a patient to accelerate death as such – rather than merely to have medical procedures held in abeyance so that disease processes can work their natural cause—depends on a broader conception of individual rights than any contained in common law principles. A right to determine when and how to die would have to rest on constitutional principles of privacy and personhood or on broad, perhaps, paradoxical conceptions of self-determination.”

Sopinka J then said:

“Although these notions have taken hold in the courts, the judiciary’s silence regarding such constitutional principles probably reflects a concern that, once recognized, rights to die might be uncontainable and might prove susceptible to grave abuse, more than it suggests that courts cannot be persuaded that self-determination and personhood may include a right to dictate the circumstances under which life is to be ended. In any event, whatever the reason for the absence in the courts of expansive notions about self-determination, the resulting deference to legislatures may prove wise in light of complex character of the right at stake and the significant potential that, without careful statutory guidelines and gradually evolved procedural controls, legalizing euthanasia, rather than respecting people, may endanger personhood.”

The learned Judge also stated that in this case, it is not disputed that, in general, sec 241(b) is valid and is a desirable legislation which fulfils the

government's objectives of preserving life and protecting the vulnerable. The complaint is that the legislature is over-inclusive because it does not exclude from the reach of the prohibition those in the situation of the appellant who are terminally ill, mentally incompetent, but cannot commit suicide on their own. It is also argued that the extension of the prohibition to the appellant is arbitrary and unfair as suicide itself is not unlawful and the common law allows a physician to withhold or withdraw life saving or life-maintaining treatment on the patient's instruction and to administer palliative care which has the effect of hastening death. The issue is whether, given this legal context, the existence of a criminal prohibition on assisting suicide for one in the appellant's situation is contrary to principles of fundamental justice.

The words, 'except in accordance with principles of fundamental justice' occurring in Art 7 of the Charter are to be interpreted in the light of common law and legislative history but a mere common law rule or historical precept may not amount to principle of fundamental justice.

The appellant asserts that it is a principle of "fundamental justice" that the human dignity and autonomy of individuals be respected and that to subject her to needless suffering in this manner is to rob her of her dignity. Respect for human dignity underlies many of the rights and freedoms in the Canadian Charter. A just balance has to be achieved between interests of the individual and those of the State. Both of which factors play a part in assessing whether a particular law violates the principles of fundamental justice. The principles of fundamental justice are concerned not only with the interest of the person who claims his liberty has been limited but with

the protection of society. Fundamental justice requires that a fair balance be struck between these interests both substantially and procedurally.

Question is whether the blanket prohibition in sec 241(b) against assisted suicides is arbitrary or unfair in that it is unrelated to the state's interest in protecting the vulnerable, and that it lacks a foundation in the legal tradition and societal beliefs which are said to be represented by the prohibition.

Section 241(b) has as its purpose, the protection of the vulnerable who might be induced in moments of weakness to commit suicide. This purpose is grounded in the State's interest in protecting life and reflects the policy of the state that human life should not be depreciated by allowing life to be taken. This policy finds expression not only in the Criminal Code which prohibit murder and other violent acts against others notwithstanding the consent of the victim, but also in the policy against capital punishment and, until its repeal, attempted suicide. This is not only a policy of the state, however, but is part of a fundamental concept of sanctity of human life. The Law Reform Commission (Canada) expressed this philosophy appropriately in its Working Paper 28, Euthanasia, Aiding Suicide and Cessation of Treatment' (1982) (at page 36):

“Preservation of human life is acknowledged to be a fundamental value of a society. Historically, our criminal law has changed very little on this point. Generally speaking, it sanctions the principle of the sanctity of human life. Over the years, however, law has come to temper the apparent absolutism of the principle, to delineate its intrinsic limitations and to define its true dimensions.”

Sopinka J stated that the principle of sanctity of life is no longer seen to require that all human life be preserved at all costs. Rather, it has come to be understood, at least by some, as encompassing quality of life considerations, and to be subject to certain limitations and a qualification reflective of personal autonomy and dignity. An analysis of our legislative and social policy in this area is necessary in order to determine whether 'fundamental principles' have evolved such that they conflict with the validity of the balancing of interests undertaken by Parliament.

As to the history of suicide provisions, at common law, suicide is a form of felony, homicide and offended against God and the king's interest in the life of his citizens (Blackstone's Commentaries, 1769, Vol 4, p 189). This was also the view first propounded by Plato and Aristotle. (M.G. Velasquez, Defining Suicide, 1987, "3 issues, in Law and Medicine", 37 at 40).

"So far as the contrary school of thought is concerned, there has been no consensus, the Roman Stoics supporting suicide (Velasquez at p 40) while Chancellor Francis Bacon preferred leaving to the doctors the duty of lessening or even ending, the suffering of their patients (L. Depaule, 'Le Droit a la mort: rapport juridique', (1974), 7 Human Rights Journal 464 at p 467)."

Burial indignities were imposed in cases of suicide in France while in England, the property of the person who committed suicide was to be taken away and his body placed at the cross-roads of two highways with a stake driven through it. As it was not possible to punish the person who committed suicide successfully, the law tried to make attempted suicide an offence. Then the Suicide Act, 1961 (42) (cl. 60) of France created an

offence of assisting suicide on the same lines as sec 241 of the Criminal Code, 1985. Attempted suicide as an offence as per sec 238 of the original Code until its repeal by statute SO in 1972 (C 13, sec 16). But the fact of decriminalization of 'attempted suicide' has no bearing on protection of assisted suicide.

So far as Medical Care at the end of life is concerned, Sopinka J surveyed the Canadian position as follows:

“Medical Care at the end of life: Canadian Courts have recognized a common law right of patients to refuse consent to medical treatment, or to demand that treatment, once commenced, be withdrawn or discontinued (Ciarlarielle vs. Schacter: 1993(2) S.C. R 119). This right has been specifically recognized to exist even if the withdrawal or refusal of treatment may result in death (Nancy B vs. Hotel-Dieu de Quebec (1992) 86 DLR (4<sup>th</sup>) 385 (Que. S.C.); and Malette vs. Shulman (1990) 72. O.R. (2d) 417 (CA). The United States Supreme Court has also recently recognized that the right to refuse life-sustaining medical treatment is an aspect of the liberty interest protected by the Fourteenth Amendment in Cruzan vs. Director, Missori Health Dept (1990) III L. Ed 2d 224. However, that Court also enunciated the view that when a patient was unconscious and thus unable to express her own view, the State was justified in requiring compelling evidence that withdrawal of treatment was, in fact, what the patient would have requested, had she been competent.

The House of Lords has also had occasion very recently to address the matter of withdrawal of treatment. In Airedale NHS Trust vs. Bland 1993(2) WLR 316, their Lordships authorized the

withdrawal of artificial feeding from a 17 year-old boy who was in a persistent vegetative state as a result of injuries suffered in soccer riots, upon the consent of his parents. Persistence in a vegetative state was found not to be beneficial to the patient and the principle of sanctity of life, which was not absolute, was therefore, found not to be violated by the withdrawal of treatment.

Although the issue was not before them, their Lordships nevertheless commented on the distinction between withdrawal of treatment and active euthanasia. Lord Keith stated (at p 362) that though the principle of sanctity of life is not an absolute one, ‘it forbids the taking of active measures to cut short the life of a terminally ill patient. Lord Goff also emphasized this distinction, stressing that the law draws a crucial distinction between active and passive euthanasia.’”

Sopinka J then quoted from Lord Goff’s judgment at pp 368-369 and said:

“Following Working Paper 28, the Law Reform Commission recommended in its (1983) Report to the Minister of Justice that the Criminal Code be amended to provide that the homicide provisions not be interpreted as requiring a physician to undertake medical treatment against the wishes of a patient, or to continue medical treatment when such treatment “has become therapeutically useless”, or from requiring a physician to “cease administering appropriate palliative care intended to eliminate or to relieve the suffering of a person, for the sole reason that such care or measures are likely to shorten the life expectancy of this person” (Report 20, Euthanasia, Aiding Suicide and Cessation of Treatment)(1983)(at pp 34-35)”.

Sopinka J continued:

“First of all, the prohibition in (sec 241) is not restricted solely to the case of the terminally ill-patient, for whom we can only have sympathy, or solely to his physician or a member of his family who helps to put an end to his suffering. The section is more general and applies to a variety of situations for which it is much more difficult to feel sympathy..... To decriminalise completely the act of aiding, abetting or counseling suicide would therefore not be a valid legislative policy. But could it be in the case of the terminally ill?

The probable reason why legislation has not been made an exception for the terminally ill lies in the fear of the excesses or abuses to which liberalization of the existing law could lead. As in the case of ‘compassionate murder’, decriminalization of aiding suicide would be based on the humanitarian nature of the motive leading the person to provide such aid, counsel or encouragement. As in the case of compassionate murder, moreover, the law may legitimately fear the difficulties involved in determining the true motivation of the person committing the act.

Aiding or counseling a person to commit suicide, on the one hand, and homicide, on the other, are sometimes extremely closely related... There is reason to fear that homicide of the terminally ill for ignoble motive may readily be disguised as aiding suicide.”

In its Working Paper (28) earlier referred to, the Law Reforms Commission had originally recommended that the consent of the Attorney General should be required before prosecution could be brought under sec 241(b).

However, after negative public response, the Commission retracted this recommendation in its final Report of 1983.

Sopinka J stated, that, therefore, while both the House of Lords and the Law Reform Commission of Canada have great sympathy for the plight of those who wish to end their lives so as to avoid significant suffering, neither has been prepared to recognise that the active assistance of a third party in carrying out this desire should be condoned, even for the terminally ill. The basis of this refusal is twofold, it seems – first, the active participation by one individual in the death of another is intrinsically morally and legally wrong, and second, there is no uncertainty that abuses can be prevented by anything less than a complete prohibition. Creating an exception for the terminally ill might frustrate the purpose of the legislation of protecting the vulnerable because adequate guidelines to control abuse are difficult or impossible to develop.”

Sopinka J then reviewed the legislation in other countries. He said nowhere assisted suicide is expressly permitted and most countries have provisions expressly dealing with assisted suicide which are atleast as restrictive as sec 241. – Austrian Penal Act, 1945 (sec 139b), Spanish Penal Code (Act 409), Italian Penal Code of 1930 (Act 580).

The relevant provision of the Suicide Act, 1961 of UK punishes a ‘person who aids, abets, counsels or procures the suicide of another or an attempt by another, to commit suicide’ and the form of prohibition is echoed in the criminal statutes of all state and tribunal jurisdictions in Australia. (M. Otlowiki, ‘Mercy Killing cases in the Australian Criminal Justice System’ (1993) 17 Crim LJ 10) The UK provision is apparently the only prohibition on assisted suicide which has been subjected to judicial

scrutiny for its impact on human rights prior to the present case. In Application No 10083/82, R vs. UK, (4<sup>th</sup> July, 1983)(D.R. 33, at p 270), the European Commission of Human Rights considered whether sec 2 of the Suicide Act, violated either the right of privacy in Art 8 or freedom of expression in Art 10 of the Convention for the Protection of Human Rights and Fundamental Freedoms. The applicant, who was a member of a voluntary euthanasia organisation, had been convicted on several counts of conspiracy to aid and abet suicide for his actions in placing persons with a desire to kill themselves in touch with his co-accused who then assisted them in committing suicide. The European Commission held (at pp 271-272) that the acts of aiding, abetting, counselling or procuring suicide were ‘excluded from the concept of privacy by virtue of their trespass on the public interest of protecting life, as reflected in the criminal provisions of the 1961 Act’, and upheld the applicant’s conviction for the offence. Further, the Commission upheld the restriction on the applicant’s freedom of expression, recognizing (at p 272).

“... the States legitimate interest in this case in taking measures to protect, against criminal behaviour, the life of its citizens particularly those who belong to especially vulnerable categories by reason of their age or infirmity. It recognizes the right of the State under the Convention to guard against the inevitable criminal abuses that would occur, in the absence of legislation, against the aiding and abetting of suicide.”

Although the factual scenario in that decision was somewhat different from the one at bar in (Canada), it is significant that neither the European Commission of Human Rights nor any other judicial tribunal has ever held

that the State is prohibited on constitutional or human rights grounds from criminalizing assisted suicide.

Some European countries have mitigated prohibitions on assisted suicide which might render assistance in a case similar to that before the Canadian Supreme Court legal in those countries. In the Netherlands, although assisted suicide and voluntary active euthanasia are officially illegal, prosecutions will not be laid so long as there is compliance with medically established guidelines. Critics of the Dutch approach point to evidence suggesting that involuntary active euthanasia (which is not permitted by the guidelines) is being practised to an increasing degree. This worrisome trend supports the view that a relaxation of the absolute prohibition takes us down ‘the slippery slope’. Certain other European countries, such as Switzerland and Denmark, emphasise the motive of the assistance in suicide, such that the Swiss Penal Code, Art 115, criminalizes only those who incite or assist a suicide for a selfish motive and the Danish Penal Code, Art 240, while punishing all assistance, imposes a greater penalty upon them who act out of self-interest. In France, while no provision of the Penal Code addresses specifically the issue of assisted suicide, failure to seek to prevent someone from committing suicide may still lead to criminal sanctions under Art 63, para 2 (omission to provide assistance to a person in danger) or Art 319 of that Code (involuntary homicide by negligence or carelessness). Moreover, the Loi no. 87-1133 du 31 decembre 1987, introduced two new articles to the Penal Code, Arts 318-1 and 318-2, which criminalize the provocation of suicide. This offence, which requires a form of incitement over and above merely aiding in the commission of a suicide, was adopted in response to the macabre impact of the book ‘Suicide, mode d’emploi’ (1982).

Similarly, a few American jurisdictions take into account whether the accused caused the victim to commit suicide by coercion, force, duress or deception in deciding whether the charge should be murder, manslaughter or assisted suicide (Connecticut, Maine and Pennsylvania), or whether the person is guilty of even assisted suicide (Puerto Rico and Indiana). (See C D Shaffer, "Criminal Liability for Assisting Suicide" (1986) 8 Columbia L Rev 348 (at pp 331-53) nn 25-26, 35-36.) As is the case in Europe and the Commonwealth, however, the vast majority of those American statutes which have statutory provisions dealing specifically with assisted suicide, have no intent or malice requirement beyond the intent to further the suicide, and those States which do not deal with the matter statutorily appear to have the common law authority outlawing assisted suicide (Shaffer, *supra*, at p 352; and M.M. Penrose, 'Assisted Suicide: A Tough Pill to Swallow' (1993) 20 Pepp. L. Rev 689 (700-701). It is notably, also that recent movement in two American States to legalise physician-assisted suicide in circumstances similar to those at bar, have been defeated by the electorates in those States. On Nov. 5, 1999, Washington State voters defeated Initiative 119, which would have legalized physician assisted suicide where two doctors certified that the patient would die in six months and two disinterested witnesses certified that the patient's choice was voluntary. One year later, Proposition 161, which would have legalized assisted suicide in California and which incorporated stricter safeguards than did Initiative 119, was defeated by California voters (usually thought to be the most accepting of such legal innovations), by the same margin as resulted in Washington – 54 to 46 per cent. In both States, the defeat of the proposed legislation seems to have been due primarily to concern as to

whether the legislation incorporated adequate safeguards against abuse (Penrose, *Supra*, at pp 708-714).

Sopinka J notes that, atleast in California, the conditions to be met were more onerous than those set out by McEachern CJ (British Columbia in the Court below) and by his dissenting colleagues in the Canadian Supreme Court, (dissenting), Chief Justice & Justice McLauchlin, in the present case.

Overall, Sopinka J, says that it appears that a blanket prohibition against assisted suicide similar to that in sec 241, is the norm among Western democracies, and such a prohibition has never been adjudged to be unconstitutional or contrary to fundamental human rights. Recent attempts to alter the status quo in USA have been defeated by the electorate, suggesting that despite a recognition that a blanket prohibition causes suffering in certain cases, the societal concern with preserving life and protecting the vulnerable, renders a blanket prohibition preferable to any law which might not adequately prevent abuse.

Sopinka J concludes that sanctity of life as a general principle is recognized in Canada and Western democracies subject to limited and narrow exceptions in situations in which notions of personal autonomy and dignity must prevail. However, those societies continue to draw distinctions between passive and active forms of intervention in the dying process, and with very few exceptions, prohibit assisted suicide in situations akin to that of Rodriguez. The task then becomes to identify the rationales upon which the distinctions are based and to determine whether they are constitutionally supportable. Sopinka J says:

“The distinction between withdrawing treatment upon a patient’s request, such as occurred in the Nancy B case, on the one hand, and assisted suicide on the other, has been criticized as resting on a legal factor – that is, the distinction between active and passive forms of treatment. The criticism is based on the fact that the withdrawal of life support measures is done with the knowledge that death will ensue, just as is assisting suicide, and that death does, in fact, ensue as a result of action taken. See, for example, the Harvard Law Review note ‘Physician Assisted Suicide and the Right to die with Assistance’ (1992) 105 Harv L Rev. 2021 (at 2030-31).

Other commentators, however upheld the distinction on the basis that in the case of withdrawal of treatment, the death is ‘natural’ – the artificial forces of medical technology which have kept the patient alive are removed and nature takes its course. In the case of assisted suicide or euthanasia, however, the course of nature is interrupted, and death results directly from the human action taken. ((E.W. Keysenlingk, Sanctity of Life or Quality of Life in the context of Ethics, Medicine and Law (1979), a Study paper for the Law Reform Commission of Canada’s Protection of Life Services). The Law Reform Commission (of Canada) calls the distinction fundamental (at p 19 of the Working Paper 28).

Whether or not one agrees that the active vs passive distinction is maintainable, however, the fact remains that under our common law, the physician has no choice but to accept the patient’s instructions to discontinue treatment. To continue to treat the patient when the patient has withdrawn consent to that treatment constitutes battery

(Ciarlariello and Nancy B, Supra). The doctor is, therefore, not required to make a choice which will result in the patient's death as he would be if he chooses to assist suicide or perform active euthanasia.

The fact that doctors may deliver palliative care to terminally ill patients without fear of sanction, it is argued, attenuates to an even greater degree any legitimate distinction which can be drawn between assisted suicide and what are currently acceptable forms of medical treatment. The administration of drugs designed for pain control in dosages which the physician knows will hasten death constitutes active contribution to death by any standard. However, the distinction drawn here is one based on intention – in the case of palliative care, the intention is to ease pain, which has the effect of hastening death, while in the case of assisted suicide, the intention is undeniably to cause death. The Law Reform Commission, although it recommended the continued criminal prohibition of both euthanasia and assisted suicide, stated, at p 70 of the Working Paper, that a doctor should never refuse palliative care to a terminally ill person only because it may hasten death. In my view, distinctions based upon intent are important, and, in fact, form the basis of our criminal law. While factually, the distinction may, at times, be difficult to draw, legally it is clear. The fact that in some cases, the third party will, under the guise of palliative care commit euthanasia or assist in suicide and go unsanctioned due to the difficulty of proof, cannot be said to render the existence of the prohibition fundamentally unjust.”

Sopinka J also refers to guidelines of medical associations. He says that the official position of the Canadian, British Medical Association, the Council of Ethical and Judicial Affairs of the American Medical Association, World Medical Association and the American Nurses Association, are all against decriminalizing assisted suicide. Given the concerns of abuse that have been expressed and the great difficulty in creating appropriate safeguards to prevent these, it cannot be said that the blanket prohibition on assisted suicide is arbitrary or unfair, or that it is not reflective of fundamental values. Art 24(h) is valid.

We are not referring to the dissenting judgments in Rodriguez.

#### Ontario Law Reform Commission:

The Ontario Law Reform Commission issued a Study Paper on ‘Assisted Suicide, Euthanasia and Foregoing Treatment’ in 1996 (running into 270 pages). It deals, in various chapters, with the definition of death (Ch. 2), Common Law (Ch. 3), Provincial legislation and Professional regulations (Ch. 4), Criminal Law (Ch. 5), Enforcing the Law: Criminal Liability, inquests and professional discipline (Ch. 6); Constitutional Rights (Ch. 7), Current Legislation and Judicial Approaches to Euthanasia and Assisted Suicide: (England and USA) (Ch. 8); Euthanasia in the Netherlands (Ch. 9); Australia (Ch. 10), Health Care Consent Act: Applying guiding principles (Ch. 11); Criminal Law; The Question of Reform (Ch. 12). The Recommendations are contained in Chapter 13. Some of them proposed accepting assisted suicide or Euthanasia, in certain situations. They are eleven in number and read as follows:

- “(1) An exemption should be added to sec 241(b) of the Criminal Code (i.e. Canada) to permit physicians (and the health care professionals acting under the direction of a physician) to assist in another’s individual suicide. The person must be either terminally ill or suffering from a chronic, irreversible illness and experiencing pain and/or suffering that he or she finds unbearable and that cannot be alleviated or treated by means acceptable to the patient. Assistance in suicide only be provided under clearly defined limits and safeguards, including a system of advance authorization. Experience with assisted suicide should be reviewed and assessed annually.
- (2) Euthanasia should remain a criminal offence.
- (3) The Criminal Code should be amended to provide for a less severe penalty in cases where an offender who took life of another individual acted out of compassion or mercy, either through the creation of a separate offence or a third category of murder, for which there would be a maximum penalty of life imprisonment but no minimum sentence, as with manslaughter. General rules for parole eligibility would apply. Instances in which motive could be taken into account in sentencing must be narrowly defined.
- (4) The question of whether policy to govern the laying of criminal charges can be developed that would give some clearer indication of how the general factors used in charging decisions apply to circumstances in which investigation reveals an individual, motivated by compassion, participated in causing

a death, should be considered by government. Reiterating existing law and restating the conundrum that, while society has a responsibility to protect life, life need not be preserved or continued at all cost, are important reminders but are not a clarification.

- (5) The Criminal Code should be amended to confirm the legality of providing necessary treatment for the purpose of eliminating or alleviating suffering, even if that treatment may shorten life. Any such amendment would only codify the law as it already exists (Rodrigues vs. B.CAG (1993)(3) SCR 519 at 607). However, concern over the legality of such measures still seems to prevail to the point where it interferes with good medical care, as evidenced particularly by inadequate management of patient's pain. If a clear statement that the practice is legal would ameliorate the substandard care many patients currently receive, then it would be advisable to incorporate one into the law.
- (6) The office of the Public Guardian & Trustee should clarify its policy on circumstances in which it considers it has jurisdiction to consent or refuse consent to 'Do Not Resuscitate Orders (DNR), bearing in mind that a plan of treatment can legitimately provide for 'the withdrawing or withdrawal of treatment in the light of the person's current health condition'. (Health Care Consent Act 1996, sec 2(1) being Schedule to the Advocacy, Consent and Substitute Decisions Statute Law Amendment Act, 1996, S.O. 1996 C. 2). This may require making decisions in advance of an

immediate need. Such a policy should be clearly communicated to physicians and other health-care professionals.

- (7) Education and training about pain management and control should be expanded and improved for health care professionals. This should include a clear statement that properly managing the patient's pain (subject to the limits of what can currently be achieved), is a duty owed to the patient and one of the standards of practice of the profession. Professional guidelines should be amended to reflect this position as well.
- (8) The relevant professional associations should be encouraged in their development of clinical practice guidelines in this area, in particular relative to the withholding and withdrawal of life-sustaining treatment and treatment at the end of life.
- (9) The government, together with the colleges and professional associations concerned and other affected groups, need to develop policies with respect to questions of futile treatment. The development of clinical practice guidelines by a professional or specialized body within the profession is important, but these issues have a societal dimensions as well. Public input should be sought in this process.
- (10) Palliative care should be supported and expanded as an important part of a comprehensive health care system.
- (11) It is essential that needed health and social services are adequately supported by government. A broad based approach should be adopted in identifying determinants of health. Regardless of

whether assisted suicide is legalized in limited circumstances or not, individuals must not be put in a position, where they may be taking end-of-life treatment decision based on or because of inadequate health care and social support.”

### Subsequent events after Rodriguez

After Rodriguez, prescription guidelines were amended in British Columbia in November 1993, in regard to doctors who complied with a patient’s request to hasten death. Public interest guidelines were included.

A Special Committee of the Senate set up in the Feb 1994 examined the legal, social and ethical issues relating to euthanasia and suicide. The Report called ‘Life and Death’ was tabled on 6 June 1995. It contains recommendations relating to palliative care, pain control and reduction practices, withholding and withdrawal of life sustaining treatment, advance directives, assisted suicide and euthanasia – non voluntary, voluntary and involuntary. ‘Active euthanasia’ means a deliberate act to end the life of a terminal or incurable patient, which in fact results in the patient’s death. ‘Active Voluntary Euthanasia’ means, it is performed at the request of the patient. ‘Active involuntary euthanasia’ is one where euthanasia is performed without the consent or against the will of a competent patient. ‘Active non-voluntary euthanasia’ means euthanasia performed on persons who are incompetent and therefore not capable of giving consent. ‘Passive euthanasia’ is the deliberate withholding or withdrawing life-prolonging medical treatment for terminal or incurable patient. This too can be voluntary, involuntary or non-voluntary.

For recommendations of the Canadian Senate Committee on assisted suicide and euthanasia see (<http://www.aph.gov.au/library/pubs/rp/1996-97/97rp4.htm>) (which deals with the development of law in several countries, including Canada).

### Australia

In regard to Australia, we shall first refer to statutes and then to the decided cases.

At the outset, it is necessary to refer to the fact that the Northern Territory enacted the ‘Rights of the Terminally Ill Act, 1995’, which legalized voluntary euthanasia and physician-assisted suicide. It came into force on 1<sup>st</sup> July, 1996. Seven patients made use of the Act. But soon the law was invalidated by the Commonwealth statute passed on 25<sup>th</sup> March 1997, called the Voluntary Euthanasia Laws Act, 1997 stating that Territorial Legislature no longer has the power to pass laws legalizing euthanasia. (It did open the possibility of the Northern Territory enacting laws regarding withholding life support.)

There are no statutes in New South Wales, Tasmania and Western Australia on the subject. They depend only on ‘dying with dignity guidelines’. South Australia, Queensland and Victoria and Commonwealth have laws which speak of ‘natural death’, providing for advanced directives and for appointment of agents or medical powers of attorney.

With the non-enforceability of the Rights of the Terminally Ill Act, 1995 of the Northern Territory, as stated above, the most relevant legislation

that remained was the Natural Death Act, 1988 which permits a person to make a direction that he or she does not wish to have ‘extraordinary measures’ used if he or she is suffering from a terminal illness. The Act does not provide for the appointment of medical powers of attorney.

In criminal law, both euthanasia and physician-assisted suicide carry heavy penalties. A doctor found guilty of aiding or abetting suicide would be liable for 10 years imprisonment under section 31C of the Crimes Act, 1900. A doctor found guilty of engaging in active voluntary euthanasia could be convicted of murder and liable for life imprisonment. (see section 19A).

Murder may have been committed by ‘acts’ or ‘omission’. Under sec 18(1) of the above Act, “Murder shall be taken to have been committed when the act of the accused, or thing by him or her assisted to be done, causing the death charged, was done or assisted with reckless indifference to human life, or with intent to kill...” with the qualification under sec 18 (2) that ‘No act or omission which was not malicious, or for which the accused had lawful cause or excuse, shall be within this section’.

In 1993, the NSW Health Dept. issued guidelines called ‘Dying with Dignity : Interim Guidelines on Management’. In November 2000, it gave the “Dying with Dignity : Revised draft guidelines for clinical decision-making at the end of life, Discussion Document.” See also, NSW Health Dept, Patient, Patient Information and Consent to Medical Treatment (Circular No. 99/10).

Since 1997, competent adults can now appoint ‘enduring guardians’ under ss 5, 6N of the Guardianship Act, 1987 (NSW). These guardians can

make decisions about medical care and treatment on behalf of a person in the event that person ceases to be competent to make decisions for him or herself. Part 5 establishes a hierarchy for determining who is the 'person responsible' for a person unable to consent to treatment. If the incompetent person is not under guardianship, then it is the enduring guardian who makes decisions regarding medical care. However, these arrangements are unlikely to have any bearing on either the active voluntary euthanasia debate or regarding decisions to withhold or withdraw treatment. This is because the purpose of the relevant provisions is to ensure that medical treatment is carried out on incompetent persons 'for the purpose of promoting and maintaining their health and well being'. (sec 32(b)). Neither the ending of a person's life nor the discontinuance of holding back treatment is contemplated by the Act.

What the NSW 'interim guidelines' say is as follows:

- (a) the patient has a right to refuse treatment.
- (b) If the patient cannot take part in the decisions, then his or her advocate should be involved.
- (c) The contents in advance directive should be taken into account.
- (d) Where there is a request for continuation of medically futile treatment, the Attending Medical Officer should consider the request in the context of the overall management plan and the best interests of the patient at that time.

- (e) Where the patient is not capable of involvement and no advocate or advance-directive has been arranged, any views that the patient was known to hold, should be taken into consideration; and
- (f) If the patients' views are not known to anyone, then decisions should be made at the discretion of the Attending Medical Officer, after consultation with the family, in the best interests of the patient.

As to Advance Directives, legislation in South Australia, Victoria and the Northern Territory and Australian Capital Territory confirm, in varying extents, the legal validity of an adult patient's anticipatory refusal of medical treatment. The statutes do them by recognizing two different mechanisms that can be used to express anticipatory refusals:

- i) 'advance directives', often referred to as 'living wills' (recognized by legislation in all the above four jurisdictions); and
- ii) 'enduring powers of attorney' for the purpose of medical decision making (recognized by legislation in South Australia, Victoria and the Australian Capital Territory only).

The advance directive provisions in these jurisdictions allow competent adults to execute formal written directives specifying their wishes concerning medical treatment. (The legislation in the AC Territory also allows competent adults to make appropriately witnessed oral directives). These directives are binding on health care professionals.

The advance directive legislation in Victoria and the AC Territory recognizes a patient's anticipatory refusal of treatment in a broad range of circumstances. The legislation in South Australia and the Northern Territory only recognizes advance directives in relation to medical treatment during terminal illness and in South Australia during persistent vegetative state, but allows a patient to express anticipatory consent to specified treatment as well as recognizing anticipatory refusals of treatment.

In South Australia, Victoria and AC Territory, there are also legislative provisions enabling a competent adult (principal) to execute an enduring power of attorney, under which the principal appoints another adult (agent) to make decisions about the principal's medical treatment in the event that the principal becomes incompetent. These decisions can include the decision to refuse or consent to most kinds of medical treatment, including life-sustaining medical treatment.

In Victoria, NT and AC Territory, the relevant legislation expressly states that it does not affect any right of a person under any other law to refuse medical treatment. It thus preserves the common law right.

The South Australia law on advance directives is in the Natural Death Act, 1983 (SA). It stated that it did not authorize 'an act that causes or accelerates death as distinct from an act that permits the dying process to take its natural course'. This Act was repealed and replaced in 1995 by the Consent to Medical Treatment and Palliative Care Act 1995 (SA) (w.e.f. 30.11.95). That deals with advance directives more exhaustively and also states that a medical practitioner or health care professional who complies with such a directive is immune from civil and criminal liability in respect of that compliance; provided that the person has also behaved in good faith

and without negligence; and in accordance with proper professional standards of medical practice and in order to preserve or improve the patient's quality of life.

The 1995 Act also introduces a regime of appointing agents to take decisions and provides similar immunity to doctors as stated above.

The Northern Territory Act 1988 is virtually identical with the South Australia Act, 1995. It does not provide for 'agents'.

Victoria directive provisions are contained in Medical Treatment Act, 1988 (vic) also deals with advance directive and provides for immunity of doctors from civil or criminal liability or professional disciplinary action. The Act also contains enduring power of attorney provisions.

Australia Capital Territory passed the Medical Treatment Act, 1994 (ACT) and is modelled on the Victoria statute of 1988. It contains also provisions for appointing agents.

Tasmania does not have any legislation for 'advance directives'. Similarly, Western Australia, New South Wales, Queensland, do not have an such law.

There have been no criminal prosecution of doctors in Australia in relation to their administration of pain relieving drugs that have hastened death. There is case law as in England which declares particular action of a doctor as lawful. Jurists have stated that a doctor may be criminally liable if he had knowledge that the patient may die as a result of the drugs administered for relieving pain if the drugs hastened the patient's death.

The limited statutory clarification is recommended by the Law Reform Commission of Western Australia that legislation be introduced to protect doctors from liability for administering drugs or other treatment for the purpose of controlling pain, even though the drugs or other treatment may incidentally shorten the patient's life provided that the consent of the patient is obtained and that the administration is reasonable in all the circumstances (see Report on Medical Treatment of the Dying, Feb. 1991, of the Law Reform Commission of Western Australia, pp. 25-27). No such legislation has, however, been enacted in Western Australia.

Only South Australia has statutory provisions that classify the law on the issue. The provisions reflect the English legal rules and the primary initiative of the doctor to relieve pain. Sec. 17(1) of the Consent to Medical Treatment and Palliative Care Act, 1995 (SA) applies to the situation where a doctor or other health care professionals, acting under a doctor's supervision, administers medical treatment 'with the intention of relieving pain or distress', even though 'an incidental effect of the treatment is to hasten the death of the patient'. This section provides that the doctor or other healthcare professional will incur no civil or criminal liability in this situation provided he or she acts:

- (a) with the consent of the patient or the patient's representative; and
- (b) in good faith and without negligence; and
- (c) in accordance with proper professional standards of palliative care.

It also provides that the administration of medical treatment for the relief of pain or distress in accordance with these conditions 'does not constitute an intervening cause of death' for purposes of the law in S.A. law.

It may also be noted that medical treatment with intention of ending patient's life and indirectly authorize 'active voluntary euthanasia'.

In Australia, attempted suicides are not an offence. But the criminal law prohibits physician-assisted suicide and makes a doctor criminally liable. Only in Northern Territory, physical assisted suicide was permitted under the Rights of the Terminally Ill Act, 1995 (NT) but as stated earlier, the federal legislation declared in 1997 (under sec. 122 of the Australian Constitution) that the State Legislature had no power to pass the above law.

In Australia, the law prohibits voluntary euthanasia except in NT during the time when the 1995 Act was in force.

(The above material as to the law in Australia is gathered from two exhaustive Research Papers 3 and 4 by Ms Natash Lica, Consultant, Law and Public Administration Group, on Passive Voluntary Euthanasia (Part 1) and Active Voluntary Euthanasia (Part 2) and are available on the website of Parliamentary Library of Australia. <http://www.aph.gov.au/library/pubs/rp/1996-97rp41.htm>)

In Victoria, the Medical Treatment Act, 1988 (Vic) provides that its operation 'does not affect any right, power or duty which a medical practitioner or any other person has in relation to palliative care'. The definition of 'palliative care' includes 'the provision of reasonable medical procedures for the relief of pain, suffering and discomfort'. The Victorian law does not expressly provide for immunity from civil or criminal law.

The Natural Death Act, 1988 (NT) is also unhelpful in not providing immunity. It provides that its operation 'does not affect the legal consequences (if any) of taking therapeutic measures (not being

extraordinary measures) in the case of a patient who is suffering from a terminal illness whether or not the patient has made a directive under the Act'. 'Therapeutic measures' are not defined. The Act in its Medical Treatment Act, 1994 (ACT) does not also provide any immunity.

Queensland passed the Criminal Code Act 1995 (Qld) which provides in sec. 82 that a person is absolved from criminal responsibility for providing 'medical treatment' (defined as including pain relief) when it is provided 'in good faith and with reasonable care and skill' for the patient's benefit and is 'reasonable, having regard to the patient's state at the time of and all the circumstances'. The section is loosely worded and may authorize 'shorter life' in circumstances not fully within the 'exceptions' stated in English law. Further, the words 'doctor or any other person' can create problems.

### Case law in Australia

1. Q vs. Guardianship & Administrative Board & Pilgrim (1998) VS (CA) (17.9.98) decided by the Victorian Court of Appeal related to a decision of the Board to appoint a 'temporary guardian', which proceeded to override an 'advance directive' of the patient that blood products be not given to her "under any circumstances". Q was a devoted Jehovah's witness. The 'advance directive' was not in compliance with the provision of the Medical Treatment Act, 1988 (Victoria) (MTA) which created a statutory scheme for such document. She was pregnant and admitted in hospital and to avoid loss of blood, an emergency hysterectomy was performed but still there was loss of blood. The hospital could not proceed to give blood transfusion in view of the advance directive.

But her husband, Mr. Q moved the Board for appointment of a Public Guardian. Persons can be placed under 'limited guardianship' when they suffer disability and are not capable of reasonable judgment (sec 33 of the Guardianship & Administrative Board Act, 1986).

The Board was not shown the advance directive but was shown an earlier 'enduring power of attorney' which was not in accordance with the MTA. It was not told why Mrs. Q refused blood transfusion. It was shown a consent form executed in hospital but that was limited to administering blood during anaesthesia. They appointed a Public Advocate as temporary guardian and made orders delegating the temporary guardianship to Mr. Q. the Board said they were not authorising blood transfusion but that they were authorizing Mr. Q to decide on that.

She was given blood transfusion and recovered and then sued the Board under sec 7 of the Administrative Law Act, 1970 (Vic) to set aside the Board's decision. Beach J summarily dismissed it.

On appeal, Wunneke J told the Board had justification since the refusal contained in the consent form only related to the administering blood during anaesthesia. That the Board could ignore. The Board had only authorised Mr. Q. The Court would be loath to create a rift between husband and wife.

The decision has been criticized, on the basis of comparative law in other countries. (see (1999) Melbourne University Law Review 6), by Cameron Stewart in his article 'Advanced Directives, the Right to Die and the Common Law: Recent problems with Blood Transfusions).

2. Northridge vs. Central Sydney Area Health Service (2000) 2000 NSW (SC) 1241 (O’Keefe J) (29.12.2000)

Mrs. Annette Northridge moved the Court at 2.56 pm on Sunday, 12<sup>th</sup> March, 2000, seeking an order preventing the administration of the Royal Prince Alfred Hospital (RPAH) from withdrawing treatment and life support from a patient, her brother, Mr. John Thompson, aged 75 years who she claimed would die if not treated or supported. The patient was admitted on 2.3.2000 in an unconscious state, having suffered a cardiac arrest as a result of an overdose of heroin.

In the judgment dated 29<sup>th</sup> Dec, 2000, Justice O’Keefe traced the subsequent history of the disagreement between the Thompson family and the RPAH medical staff regarding the termination of antibiotic treatment for the patient on 9<sup>th</sup> March 2000 and subsequent health care decisions. It was explained that the medical staff had formed the view that Mr. Thompson was in a ‘chronic vegetative state’ and that any further treatment would be ‘futile’. Due to the Court’s intervention, treatment was resumed and at the date of judgment the patient was ‘unarguably alive’. The Court referred to the Practice Note (1996 (4) ALL ER 766) of UK.

O’Keefe first referred to ‘jurisdiction’ of the Court and held that the ‘parens patriae’ jurisdiction was available to the Court to deal with person and property of those under disability. He referred to the history of this jurisdiction and also relied on the judgment of the House of Lords in Re F (Mental Patient: Sterilisation) 1990(2) AC. 11 in that behalf and applied to unconscious patients. He referred to Mariam’s case (1991-2) 175 CLR 218)

The Judge criticized the absence of guidelines by the medical profession in Australia and referred to the exhaustive guidelines of the GMC (UK). He held that the hospital had no explanation as to the criteria it followed to hold that Mr. Thompson was in a 'vegetative state'. Dr. Danes had stated that the patient was not 'brain dead' and that though the patient could not take care of himself, there could be nursing care, as opposed to intensive or other hospital care. The family complained that the doctors were not communicating with them and they stopped antibiotics and would not feed him. They suspected that the Hospital was interested in the organs of the patient for transplantation.

The Judge held that the 'evidence reveals a lack of communication, a premature diagnosis, an inadequate adherence to the hospitals' own policies in relation to consultation with relatives and an absence of recognized criteria for the making of the diagnosis of 'vegetative state'. Significantly, it emerges as common ground that within a matter of days after admission Mr. Thompson was dealt with on the basis that any treatment was futile. This was far too short a time after his injury for these not to be a serious risk of misdiagnosis, as provided to be the case.'

O'Keefe pointed out that it was 'precisely because of such a risk that a standard and guidelines have been adopted in the United Kingdom in relation to vegetative state, continuing vegetative state and permanent vegetative state.' "In addition, transferring Mr. Thompson into a renal transplant ward after treatment and 'feeding had been discontinued and a 'Not for Resuscitation order' imposed, could not help but give rise to a

perception that there was a conflict of interest in relation to his treatment and management. I hasten to add that I accept that there was no proposal by the hospital or the doctor to use his organs as transplants after his death. However, in life and death situation, it is important that any conflict of interest or circumstance that may give rise to an apprehension of conflict of interest be avoided, in the same way as bias and the apprehension of bias must be avoided in relation to the judicial determination of the rights of the individuals.”

The Judge found that, by 29<sup>th</sup> Dec. 2000, the patient admitted in March 2000 was still alive, he moves, responds, is able to walk, articulate and to control a number of muscular and bodily functions. According to the material last put before the Court, he was then in a nursing home under the control of the defendant (hospital).

The Judge deprecated the lack of medical standards in Australia to infer if a patient was a ‘PVS’, for which in UK, detailed procedures were formulated by the General Medical Council, UK.

In UK, there is scope for seeking a declaration that *“the responsible medical practitioners... may lawfully discontinue all life sustaining treatment and medical support measures, (including ventilation, nutrition and hydration by artificial means) designed to keep (the patient) alive (his or her) existing permanent vegetative state.”*

The Practice Note 1996(4) All ER 766 points out that the standard form of relief recognizes that there may be a material change in the existing

circumstances before such withdrawal by providing that any party has liberty to apply for such or other declarations or order as may be appropriate.

The Judge held that there was a requirement to get court sanction in every case where the ANH is proposed to be terminated (this appears to be not correct in view of the Judgment of the Court of Appeal in Burke in 2005).

He held on facts that the withdrawal of treatment and nutrition for Mr. Thompson was premature. A person to be PVS must be in that state for a 'lengthy period' in which there is no change in the state of consciousness. The subsequent treatment and his revival 'highlight the wisdom of allowing a sufficient time to pass between the trauma or other event giving rise to the unconscious state of the patient and the making of a diagnosis of permanent or (chronic) vegetative state, which may be a prelude to withdrawal of treatment, support and nutrition'.

The Judge directed that until further orders, Mr. Thompson be provided appropriate life preserving treatment, and that no 'Not for Resuscitation Order' be made without prior leave of Court.

3. Issac Messiha vs. South East Health = 2004 NSW SC 1061 (11<sup>th</sup> Nov 2004 (Howie J).

This case led to a result contrary to the one in Northridge. The opinion of the doctors was to withdraw treatment (and give only palliatives)

on the ground that the patient was PVS and not likely to revive, was accepted by the Court. The Court accepted this view and the application on behalf of the patient was rejected.

Mr. Messiha was admitted in ICU on 17<sup>th</sup> October, 2004. He had suffered an asystolic cardiac arrest: that is, his heart had completely stopped beating, depriving his body, including his brain, of the supply of oxygen. As a result, since his admission, he has been unconscious and apparently in deep coma. Dr. Mrs. Jacques, Director of the Unit of the respondent was of the view that the current treatment regime of the patient should cease and that he should be removed from the Unit and placed under palliative care. She accepts that withdrawing treatment in the Unit will have the effect of reducing life expectancy from possibly weeks to possibly days. The members of the family of the patient approached the Court to restrain Dr. Jacques and other medical staff at the hospital from altering the patient's treatment. The family believed that the patient would improve if the treatment was continued and he would live for a longer time.

The learned Judge held, following Northridge that the Court has *parens patriae* jurisdiction in such cases.

After considering the views of Dr. Jacques and other experts, the Court held that there was no eye-movement observed and that the present state was that the patient (a) was mechanically ventilated through a tube in his mouth and passing down his trachea, (b) being fed and hydrated through a tube in his mouth and through his arm, (c) was not able to pass urine artificially, (d) incontinent of faeces, (e) was unable to swallow his own

saliva requiring suctioning of his mouth, nose and throat and (f) his eyes are taped down in order to prevent corneal ulcers. The medical evidence was unanimous that there was no real prospect of recovery. The Court was satisfied that there was no medical evidence to say that he was not in a PVS state. The application by family members to restrain the doctors from withdrawing medical treatment was rejected.

## New Zealand

In New Zealand, voluntary euthanasia is illegal. The Death with Dignity Bill, 2003 which intended to provide terminally and incurably ill people to seek medical help to end their lives was defeated in Parliament on 30<sup>th</sup> July 2003. (The Bill permitted 'assisted suicide')

Voluntary euthanasia is allowed only in two countries, Netherlands and Belgium and it was permissible for a short period in Australia's Northern Territory during 1996-97. Oregon permitted physician-assisted suicide in 1994.

Section 179 of the Crimes Act, 1961 (NZ) stipulated a prison term of 14 years to every person who

- (g) incites, counsels or procures any person to commit suicide, if that person commits or attempts to commit suicide in consequence thereof; or
- (h) aids or abets any person in the commission of suicide.

Section 151 stated that every one who has charge of any other person unable, by reason of detention, age, sickness, insanity, or any other cause, to withdraw himself from such charge, and unable to provide himself with the necessaries of life, is (whether such charge is undertaken by him under any contract or is imposed upon him by law or by reason of his unlawful act or otherwise howsoever) under a legal duty to supply that person with the necessaries of life, and is criminally responsible for omitting without lawful

excuse to perform such duty if the death of that person is caused, or if his life is endangered or his health is permanently injured, by such omission.

Under sec 8 of the NZ Bill of Rights Act, 1996, 'No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice'.

We shall refer to a case in New Zealand decided by Thomas J, interpreting the above sections. This judgment of Thomas J received praise at the hands of the House of Lords in Airedale.

Auckland Area Health Board vs. Attorney General =1993(1) NZLR 235 (13.8.92) (Thomas J)

This is one of the best judgments on the subject and received praise from the House of Lords in Airedale.

A doctor of the ICU of Auckland Hospital made an application, along with the Auckland Area Health Board, for a declaration clarifying whether, in law, they would be guilty of culpable homicide under ss 151(1) or 164 of the Crimes Act, 1961, if they were to withdraw the ventilatory support system which maintained the breathing and heartbeat of a patient with an extreme case of Guillian-Barre Syndrome. The disease affected the nervous system destroying the conductivity of the nerves between the brain and the body. The result was to leave the brain, though still living, entirely disengaged from the body. The patient survived in a state of 'living death', totally unable to move or communicate and there was no prospect of

recovery. However, because the brain, though damaged, was not dead, the patient was not medically 'brain-stem dead' as per the medical definition of 'death. The patient existed in that condition for 12 months. Eight specialists were unanimous that the ventilatory support could not be medically justified. In that approach, the medical team had the informed concurrence of the patient's family and the approval of the hospital ethical committee. If the life support system was withdrawn, death would be instantaneous.

The issue before the Court was whether in the circumstances, the doctors' action in withdrawing the artificial ventilatory-support system from Mr. L would make them guilty of culpable homicide. As part of the issue, the Court had also to consider whether a doctor was obliged to continue treatment which had no therapeutic benefit. The Court had also to determine a threshold issue as to the appropriate involvement of the Attorney-General.

Thomas J held that, as the proceeding raised matters of general public importance and the relief sought, if granted, would impinge upon prosecutorial discretion and prerogatives of the Crown, leave for the Attorney General to be heard as intervener be granted. (Adams vs. Adams: 1970(3) All ER 572 applied)

It was also held that the Court had jurisdiction to grant a declaratory relief even though the declaration related to a matter which could be the subject of criminal proceedings. Such jurisdiction should be sparingly exercised. Any civil ruling on an issue which fell for consideration in any

criminal proceedings undertaken in respect of the same subject-matter would not be binding on the Court in the exercise of its criminal jurisdiction. Any unsatisfactory features relating to the making of a declaratory order were outweighed by the desirability of providing the doctors in the circumstances of the case with a ruling as to the lawfulness of their action. Any declaration could be worded in such a way as to overcome the difficulty of the Court being asked to make a declaration relating to future conduct.

Dyson vs. vs. AG (1911)(1) K B 410 (CA)

Sankey vs. Whitlam: (1978) 142, CLRI

Imperial Tobacco vs. AG: 1980(1) All ER 866 (HL)

R vs. Sloan: 1990(1) NZLR 474.

Accepting the jurisdiction of Court but with a discretion to use it sparingly is a better principle since there may be circumstances where it is clear that the criminal process is being used vexatiously and the criminal proceeding amounts to an abuse of process. The Court must be prepared then to say so and to step in and bring the vexatious proceeding to an end. At other times, as illustrated by the cases referred to, the Court can properly and usefully resolve a legal issue in advance of a criminal proceeding.

It is true that the above cases involve offences of a regulatory nature. Nevertheless, the offences have been properly regarded as ‘crimes’. Nor is there any reason to draw a distinction between crimes of a regulatory kind and crimes which may involve an element of moral turpitude. Any such distinction was rejected by the High Court of Australia in Sankey vs.

Whitlam (1978) 142 CLR. 1, referred to with approval in R vs. Sloan (1990) (1) NZLR 474 by Hardie Boys J.

It would be unsatisfactory to make the power of the Court depend upon so arbitrary and uncertain a test. Such matters are best left to be considered by the Court in the exercise of its jurisdiction.

In exercising a discretion in a case like the present, there are a number of matters which should be taken into account. Two important matters, may, however, require to be mentioned.

First is that a decision of the Court would tend to have the effect of usurping the function of the criminal Court. “In most cases, I agree, it would be totally inappropriate to make a declaration in the Court’s civil jurisdiction which would pre-empt a decision of the Court in its criminal jurisdiction. In this case, however, the doctors are in an invidious position. On the one hand, they have that duty to their patient and their professional responsibility to adhere to good medical practice; on the other hand, if they act in accordance with their conscience, they face the threat of criminal proceedings alleging that they are guilty of unlawful killing. This point outweighs the general importance of not intervening in a criminal proceeding in a manner which might displace or affect the exercise of the Court’s criminal jurisdiction.”

Nevertheless, a civil ruling on an issue which will fall for consideration in any criminal proceedings which are undertaken in respect of the same subject matter will not be binding on the Court in the exercise

of its criminal jurisdiction. Lord Lane put it in this way in Imperial Tobacco Ltd. vs. AG: 1980(1) All ER 866 (HL):

“The criminal law would not be bound by the decision. In practical terms, it would simply have the inevitable effect of prejudicing the criminal trial one way or another.”

Viscount Dilhorne also spoke of the use which might be made at the criminal trial of a declaration in a civil Court that no crime had been committed. It is clear from his Lordship’s remarks that he used the word ‘used’ in the sense of ‘misuse’ and considered that the integrity of the criminal proceedings would be adversely affected.

The fact that a declaratory order of the Court would not be binding in any criminal proceeding must be a telling factor against making any order at all. Nor is it appropriate that a ruling of the Court on its civil jurisdiction should be available to be used or misused, by the combatants at the criminal trial. But, these unsatisfactory features are again outweighed by the desirability of providing the doctors in the circumstances of this case, with a ruling as to the lawfulness of their actions.

The second factor which relates to the exercise of the Court’s discretion is the fact that “the Court would be effectively making a declaration relating to future conduct. The facts before the Court now need not necessarily be the facts which exist at the time the doctors withdraw the ventilator-support system. The imprudence of making a declaration on the basis of future acts is well-established. Yet, in this case, it is justified. For

one thing, the facts are settled. Mr. L is not going to recover, nor will his condition even improve. Moreover, it is expected that if there is a material change in the facts, such as Mrs. L changing her mind or the ethics Committee receiving their earlier endorsement, the doctors would act responsibly, any declaration can be worded in such a way as to overcome the difficulty. Whatever be the form, the doctors are entitled to an indication from the Court as to whether or not their action will be lawful.”

The learned Judge then referred to ‘sanctity of life’ as a deep-rooted value imminent in our society and its presentation as a fundamental humanitarian precept. He then referred to section 8 of the N.Z. Bill of Rights Act, 1990 which states:

“Section 8: Right not to be deprived of life: No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice.”

The learned Judge observed that that was not to say that the sanctity of life represented an absolute value. Few, if any, value could be stated in absolute terms. The qualification in sec 8 itself conferred that to be the case. It was also illustrated by the fact that a person might refuse medical treatment. Section 11 of the N.Z. Bill of Rights Act, 1990 states: “Everyone has the right to refuse to undergo any medical treatment”. It has been held also that where one cannot accord with the view that this right enabled a patient, properly informed, to require life-support systems to be discontinued. In Nancy B vs. Hotel – Dieu de Quebec (1992) 86 DLR (4<sup>th</sup>) 385, the Quebec Supreme Court was faced with the same problem. The patient suffered from

Guillan-Barre syndrome and was incapable of movement. She could breathe only with the aid of a respirator. But her intellectual capacity and mental competence were unaffected. Her condition was diagnosed as ‘irreversible and incurable’ and she wanted it to be brought to an end. She commenced an action seeking injunction against the hospital and her physician requiring them to withdraw the respirator. The injunction was granted. It was held that the use of respirator to sustain ‘life’ was medical treatment but that the discontinuance of that treatment at the patient’s request would not constitute a criminal act. Rather, it “allowed nature to take its course”.

Nancy B also highlights another set of values which are central to our concept of life; values of human dignity and personal privacy. See also Matter of Nancy Ellen Jobes (1987) 529 A 2d 434.

The problem arises when life passes into death but obscurely. It is a problem made acute by the enormous advances in technology and medical science in recent decades. With the use of sophisticated life support systems, life may be perpetuated well beyond the reach of the natural disease. The process of living can become the process of dying so that it is unclear whether life is being sustained or death being deferred.

This is the plight of the irreversibly doomed patient. Maintained by mechanical means they exist suspended in a state of moribund inanimation. Whether a body devoid of a mind or as in the case of Mr. L, a brain destitute of a body, does not matter in any sensible way.

In their chronic and persistent vegetative condition, they lack self-awareness or awareness of the surroundings in any cognitive sense. They are the 'living dead'. Whether, in such circumstances, or in this particular case, it is fairer to say that life-support system is being used to sustain life or being used to defer death is at the heart of the question.

The learned Judge then discussed the issue under the heading 'The living dead'. Over time, the medical community's perception of what constitutes 'death' has changed. The general community's principles has also changed but has lagged somewhat behind that of the doctor's. Originally, it was thought that the absence of the 'vital functions', (absence of) a heart beat and breathing, signified death. That is not the view doctors share today. With the advances in technology and medical skills which have occurred, the medical profession has rejected the notion that death is to be equated with the cessation of a person's heartbeat. In open heart surgery, for example, the patient's heart is temporarily stopped, but it is not thought that he or she has died. Instead, the medical community has preferred the concept of what is called 'brain death'. In England, the Conference of Medical Colleges and their Faculties of the UK has resolved that, when irreversible brain damage is diagnosed and it is established by tests that none of the vital centres in the brain system are still functioning, the patient is to be accounted dead: (1979)(1) British Medical Journal p 332). Though this definition is not formally adopted in New Zealand, it is widely accepted throughout the medical profession as being a more accurate indication as to when death occurs.

‘Brain Death’ according to Ian Kennedy is ‘the state which has traditionally been regarded as death in a human being is reached when the brain, including the brain stem, is destroyed. A person will not breathe, nor will his heart beat, without a functioning brain-stem; and if this is destroyed, he will never recover the ability to do so, since, once destroyed, brain cells do not regenerate’ (‘Switching off Life Support Machines: Legal Implications’, ‘Treat me Right’) (1988) pp 351-352).

Breathing and heartbeat, however, can be mechanically induced. This is, of course, what occurs when an artificial respirator is applied. Breathing and heartbeat are maintained, and may be maintained indefinitely, even though the person is medically dead. In such a case, the ventilator is ‘merely ventilating a corpse’ (ibid p 352).

So far as Mr. L is concerned, his upper brain is damaged, he is alive but the nerve complex which connects his brain to his body is totally destroyed and cannot be regenerated. Spontaneous breathing and heartbeat are irreversibly lost as if he were brain-stem dead. Breathing and heartbeats, the outward manifestations of life, are also mechanically induced. The difference between the two cases is a matter of medical description, but both descriptions are, perhaps, equally apt to describe the ‘living dead’.

Mr. L is ‘living dead’ but may not be ‘brain-stem dead’.

The learned Judge then referred to sec 151 of the (NZ) Crimes Act, 1961 which deals with ‘Duty to provide necessaries of life’. It reads:

“Section 151: Duty to provide the necessaries of life: (1) Everyone who has charge of any other person unable, by reason of detention, age, sickness, insanity or any other cause, to withdraw himself from such charge, and unable to provide himself with the necessaries of life, is (whether such charge is undertaken by him under any contract or is imposed upon him by law or by reason of his unlawful act or otherwise howsoever) under a legal duty to supply that person with the necessaries of life, and is criminally responsible for omitting without lawful excuse to perform such duty if the death of that person is caused, or if his life is endangered or his health permanently injured, by such omission’.

After referring to various aspects relating to moral and legal duties of doctors and the wrong media-description of doctors’ decisions, the learned Judge stated that the basic question was whether “the doctor was legally justified in doing what he did. Essentially, this is to ask whether the doctor was under a duty to continue the life-support system or had a ‘lawful excuse’ for withdrawing it?

If the doctor was not under a legal duty to provide or continue with life-support system, or he had a ‘lawful excuse, for discontinuing it, it may then be said that he or she had not legally caused the death of the patient, the Judge said.

As to the duty to provide ‘necessaries of life’, sec 151 applies to patients under medical care. Medical treatment is included in ‘necessaries

of life'. R vs. Books : (1902)(9) BCR 13. So is medical attention R vs. Morre: (1954) NZLR. But these are actions intended to 'prevent, cure or alleviate disease' that threatened life of health: R vs. Tutton : (1989) 48 CCC (3d) 129.

No precedent is available which said that a 'ventilator' is a 'necessary of life'. But, the question is not capable of absolute answer. It must depend on the facts. A provision for artificial respirator may be regarded as a necessary of life where it is required to 'prevent, cure or alleviate a disease that endangers the health or life of the patient'. If, however, the patient is 'beyond recovery', a ventilator is not to be treated as a necessary of life. "It is repugnant that a doctor who has in good faith and with complete medical preparatory undertaken treatment which has failed, should be held responsible to continue that treatment on the basis that it is, or continues to be, a necessary of life". Artificial ventilation may, in several cases, enable the patient to live longer and recover. It has therapeutic or medical functions.

Even if it could be said that doctors are under a duty to provide ventilator, they are legally justified in withdrawing it if there was a 'lawful excuse'. The Court of Appeal in R vs. Burney (1958) NZLR 745(CA) (at 753), accepted the following dicta of the Privy Council in Wang Pooch Yun vs. Public Prosecutor: (1955) AC 93 (at 100).

"Their Lordship's doubt if it is possible to define the expression 'lawful excuse' in a comprehensive and satisfactory manner and they do not propose to make an attempt. They agree with the Court of

Appeal that it would be undesirable to do so and that each case requires to be examined on its individual facts.”

The Judge then held that doctors have a ‘lawful excuse’ to discontinue ventilation when there is no medical justification to continuing that form of medical assistance or where there is no medical function or purpose and where it serves ‘only to defer the death of a patient’. It is not the purpose of medical treatment to merely prolong the life of a person for no benefit. It is not unlawful to discontinue the support ‘if the discontinuance accords with good medical practice’. The words ‘good medical practice’ cannot again be defined absolutely and their meaning depends on the fact situation. The words refer to a ‘bona fide’ decision on the part of the attending doctors as to what, in that judgment, is in the ‘best interests’ of the patient. They also refer to the ‘prevailing medical standards, practices, procedures and conditions which command the general approval of the medical profession’. All relevant tests need to be carried out, special list opinions need to be taken, where necessary. Medical body’s ethics committees can be consulted. The patient’s family or guardian must also be informed.

In the present case, the decision to discontinue has been taken by a number of medical specialists and others. It was endorsed by the medical ethical body. Informed consent of family members was obtained. Thus, there is the assurance of ‘good medical practice’.

Such an approach was followed by the Supreme Court of New Jersey in US in 'In the matter of Karen Quilan': (1976) 355 Azd 647. See also Barber vs. Superior Court of State of California (1983) 195 Cal Rep 484.

Question of 'good medical practice' forms the basis of a number of decisions in UK too which enable the doctors to perform sterilisation upon adults unable to consent to such operations because of mental disability. I vs. I: (1988 (1) All ER 613; F vs. Bukhire Health Authority (1989)2 All ER 545. There is also persuasive support for Re J (a minor) 1992 TLR 29 of the UK Court of Appeal.

The realistic approach above mentioned has been accepted by leading jurists. Prof. Ian Kennedy has observed that death is not always necessarily an evil to be prevented and that, as a consequence, a doctor may, in appropriate circumstances, be entitled to embark on conduct which involves ceasing to seek to prevent death and could, as it happens, bring it about (Kennedy, pp 361-367). Again Prof. Williams (p 279) states:

"A doctor must not do anything actively to kill his patient, but he is not bound to fight for the patient's life forever. His duty in this respect is to make reasonable efforts, having regard to the customary practice and expectations, and in particular, having regard to the benefit to the patient to be expected from further exertions. He need not and should not crassly fix his attention upon mere heartbeats'.

Medical science and technology was never intended that it be used to prolong biological life in patients bereft of the prospect of returning to an

even limited exercise of human life. Natural death may be deferred but it need not be postponed indefinitely. For example, in case of patients suffering from cancer where there is no hope of recovery, doctors can administer palliative drugs even if they have the effect of hastening death.

Hence under sec 151, a doctor acting responsibly and in accordance with good medical practice cannot be made liable for any criminal offence. He must be taken as having had a 'lawful excuse'.

Withdrawal of ventilator is not the cause of death as a matter of law if and when two primary conditions are met: (a) the doctor acted under a duty to provide ventilator as part of the necessities of life or (b) that doctor has a lawful excuse for declining to do so; both depend on whether he follows good medical practice or guidelines or procedures which have been laid down.

Section 164 of the Crime Act, 1961 speaks of 'acceleration of death'. It reads:

"Sec 164: Acceleration of death. Every one who by any act or omission causes the death of another person kills that person, although the effect of the bodily injury caused to that person was merely to hasten his death while labouring under some disorder or disease arising from some other cause."

If the 'cause of death' is not the criminal intent of the doctor but is based on good medical practice and if that is good for sec 151, it is also good for sec

164. The withdrawal of support is not an ‘unlawful’ act for purpose of sec 160 in determining whether a homicide is culpable or not. It cannot be regarded as an unlawful act when the doctors concerned are not in breach of duty and have a lawful excuse.

Again, the victim must have, for purpose of sec 164, suffered a ‘bodily injury’ at the hands of the accused. It strains sec 164 while applied to a patient already in ‘irreversible’ condition. A ventilator mechanically ventilates, its withdrawal cannot be treated as inflicting ‘bodily injury’.

A doctor who decides to stop the ventilator on the basis of good medical practice cannot be treated as having ‘hastened’ another’s death, where that ‘treatment’ serves no therapeutic or medical purpose.

The Judge finally granted a declaration and declared that the action did not amount to ‘culpable homicide’ within sections 151, 164 of the Crimes Act, 1961. He declared:

“If:

- (i) the doctors responsible for the care of Mr. L, taking into account a responsible body of medical opinion, conclude that there is no reasonable opportunity of Mr. L ever recovering from his present condition;
- (ii) there is no therapeutic or medical benefit to be gained by continuing to maintain Mr. L on artificial ventilatory support, and to withdraw that support accords with good

medical practice, as recognized and approved within the medical profession; and

- (iii) Mrs. L and the ethics committee of the Auckland Area Health Board concur with the decision to withdraw the artificial ventilatory support;

then, ss 151 and/or sec 164 of the Crimes Act 1961, will not apply, and the withdrawal of the artificial ventilatory support from Mr. L will not constitute culpable homicide for the purposes of that Act. The order prohibiting publication of L's name or any particulars which might lead to his identification, is continued.”

The Judge also directed, in his judgment dated 13<sup>th</sup> Aug. 1992, prohibition of publication of any part of his judgment till 28 Aug., 1992.

We are of the view that these principles must be brought into the proposed draft Bill in India.

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South Africa:

In Nov. 1998, the South African Law Commission, gave a Report (Project 86) on ‘Euthanasia and the artificial preservation of life’ (running to 237 pages).

The Report was preceded by a Discussion Paper (No. 71) (Project 86) of 1997 running into 86 pages.

The Report of 1998 contains six chapters. Chapter I contains the ‘Introduction’; Chapter II deals with ‘Technology and Definitions’; Chapter III deals with ‘Artificial Preservation of Life where the patient is clinically Dead’; Chapter IV deals with ‘Cases where the patient is competent to make decisions’, and this chapter is divided in 5 parts: (A) cessation of life-saving medical treatment of the competent person, (B) Double effect, (C) Assisted suicide, (D) Voluntary active euthanasia, (E) Involuntary active euthanasia; Chapter V deals with ‘The Incompetent Patient who has no prospect of recovery or improvement’ and is divided in three parts: (A) Cessation of Life-sustaining medical treatment where there is an advance-directive (living will) or power of attorney, (B) cessation of life sustaining medical treatment where there is no advance directive (living will) or power of attorney, (C) Non-voluntary active euthanasia; Chapter VI contains draft Bill on end of life decision; Annexure ‘A’ contains a list of respondents to working paper 53; Annexure ‘B’ gives a list of respondents to discussion Paper 71; Annexure ‘C’ contains a final draft Bill on end of life decision.

We do not propose to discuss the Report in detail but the final recommendations in the Report are as follows:

### Summary of Recommendations

The advances made in medical science and especially the application of medical technology have resulted in patients living longer. For some patients this signifies a welcome prolongation of meaningful life, but for others the result is a poor quality of life which inevitably raises the question whether treatment is a benefit or a burden.

Worldwide increased importance is furthermore being attached to patient autonomy. The need has therefore arisen to consider the protection of a mentally competent patient's right to refuse medical treatment or to receive assistance, should he or she so require, in ending his or her unbearable suffering by the administering or supplying of a lethal substance to the patient. The position of the incompetent patient, as well as the patient who is clinically dead, has to be clarified as well.

Some matters concerning the treatment of terminally ill people are at present being dealt with on a fairly ad hoc basis, there is some degree of uncertainty in the minds of the general public and medical personnel about the legal position in this regard. Doctors and families want to act in the best interest of the patient, but are unsure about the scope and content of their obligation to provide care. Doctors are furthermore afraid of being exposed to civil claims, criminal prosecution and professional censure should they withhold life support systems or prescribe drugs which may inadvertently or otherwise shorten the patient's life, even if they are merely complying with the wishes of the patient.

The South African Law Commission recommended the enactment of legislation to give effect to the following principles:

“A medical practitioner may, under specified circumstances, cease or authorize the cessation of all further medical treatment of a patient whose life functions are being maintained artificially while the person

has no spontaneous respiratory and circulatory functions or where his or her brainstem does not register any impulse.

A competent person may refuse any life-sustaining medical treatment with regard to any specific illness from which he or she may be suffering, even though such refusal may cause the death of such a person.

A medical practitioner or, under specified circumstances, a nurse may relieve the suffering of a terminally ill patient by prescribing sufficient drugs to control the pain of the patient adequately even though the secondary effect of this conduct may be the shortening of the patient's life.

A medical practitioner may, under specified circumstances, give effect to an advance directive or enduring power of attorney of a patient regarding the refusal or cessation of medical treatment or the administering of palliative care, provided that these instructions have been issued by the patient while mentally competent.

A medical practitioner may, under specified circumstances, cease or authorize the cessation of all further medical treatment with regard to terminally ill patients who are unable to make or communicate decisions concerning their medical treatment, provided that his or her conduct is in accordance with the wishes of the family of the patient or authorized by a court order.”

As regards ‘active voluntary euthanasia’, the Commission does not make a specific recommendation. The Commission sets out different options to deal with this issue. These options were identified through comments received:

“Option 1: Confirmation of the present legal position:

The arguments in favour of legalising euthanasia are not sufficient reason to weaken society’s prohibition of intentional killing since it is considered to be the cornerstone of the law and of all social relationships. Whilst acknowledging that there may be individual cases in which euthanasia may seem to be appropriate., these cannot establish the foundation of a general pro-euthanasia policy. It would furthermore be impossible to establish sufficient safeguards to prevent abuse.

Option 2: Decision making by the medical practitioner:

The practice of ‘active euthanasia’ is regulated through legislation in terms of which a medical practitioner may give effect to the request of a terminally ill, but mentally competent patient to make an end to the patient’s unbearable suffering by administering or providing a lethal agent to the patient. The medical practitioner has to adhere to strict safeguards in order to prevent abuse.

Option 3: Decision making by a panel or committee:

The practice of ‘active euthanasia’ is regulated through legislation in terms of which a multi-disciplinary panel or committee is instituted to consider requests for euthanasia according to set criteria.”

## **Chapter VII**

### Legal Principles applicable in India and position

#### Under Indian Penal Code, 1860

As stated in the opening para of Chapter I, this Report is not intended to legalise Euthanasia or Assisted Suicide. This Report refers to a different subject, namely, withholding or withdrawal of life support from competent and incompetent patients who are terminally ill. In the case of competent patients, if they agree for such withholding or withdrawal on the basis of their informed decision and in the case of incompetent patients, if doctors consider it to be in their best interests,- it is lawful for the doctors to withhold or withdraw medical treatment, including artificial nutrition and hydration. Universally, in all countries, such action is treated as lawful and as being different from Euthanasia or Assisted Suicide.

We have stated in Chapter I that in this Report, we do not propose to follow the traditional pattern of preparing a Report, nor the method of presentation that was being followed by other Law Commissions. This, we explained, was because of our desire to furnish as extensive information as possible on the facts of each case medical case where life-support withdrawing or withdrawal became important. If we should merely refer only to the abstract legal propositions and give citations of relevant case law where some principle is decided by the Courts, then law makers, doctors, hospital authorities, lawyers and Judges would find it difficult to know in what factual background what medical decisions were taken and why such medical decisions were either held valid or invalid by the Courts. The issue

being one concerning 'life', serious concerns of human rights of the patient arise. The doctors and hospitals would want to know in what circumstances they might become vulnerable to civil or criminal action. In fact, unless the factual background of each case is fully presented, the Report, if it merely contained legal propositions, would not be of any help.

Therefore, we decided to present a new type of Report where the facts of each case are dealt with in sufficient detail and then the legal principles that are extracted at considerable length in each case. We have done so in the previous chapters. In this Chapter, we shall refer to the important principles laid down in leading cases which, according to us, should be applicable in our country. These can be listed as follows:

Principles which are proposed to be discussed in this Chapter for application in our country:

- (1) Advances in science and technology and concepts of brain-stem death.
- (2) Euthanasia and Assisted Suicide are and shall continue to be criminal offences in India but not withholding or withdrawal of life supporting systems.
- (3) Adult patients' right of self determination and right to refuse treatment is binding on doctors if it is based on informed decision process.
- (4) Giving invasive medical treatment contrary to a patient's will amounts to battering or in some cases may amount to murder.

- (5) Advance directives (living wills); and powers of attorney in favour of surrogates to be invalid in our country;
- (6) State's interest in protecting life and principle of sanctity of life are not absolute.
- (7) Refusal to obtain medical treatment does not amount to 'attempt to commit suicide' and withholding or withdrawing medical treatment by a doctor does not amount to 'abetment of suicide'.
- (8) Competent and incompetent patients, 'informed decision' and 'best interests' of the patients, consultation with a body of three experts before treatment is withheld or withdrawn.
- (9) Statutory body to prepare panel of experts.
- (10) The Court has power, in appropriate cases, to grant declaration that, on the facts of the particular case, the giving or withholding or withdrawing invasive medical treatment is lawful.
- (11) Does the Court's declaration provide immunity to doctor from civil or criminal action in subsequent litigation, civil and criminal.
- (12) Palliative care can be given to patients to relieve pain and sufferings even if, in some cases, it may adversely affect health of the patient.
- (13) Confidentiality to be maintained whether declaration is sought in Court or not.
- (14) Guidelines by the Medical Council of India in consultation with experts and the Indian Society for Critical Medical Care.

(As to (8) above, for the purposes of 'informed consent', one may also refer to a very good article by Prof. B.S. Venugopal, Vice-Principal, V.B. College of Law, Udipi, Karnataka in (2004) Journal of Indian Law Institute, p 393).

(1) Advances in science and technology and concepts of brain-stem death:

Science and technology developments in the last century have altered concepts of life and death. Today, a person who is in a persistent vegetative state, whose sensory systems are dead can be kept alive by ventilators and artificial nutrition for years. Heart may be stopped during open-heart surgery but the patient can be kept alive artificially. In scientific parlance, the body is treated as dead only if the 'brain-stem' becomes dead. Once brain stem is dead, the brain cells cannot be regenerated and it is at that stage a person is treated as dead.

The Indian statute, 'Transplantation of Human Organs Act, 1994 defines 'brain stem death' in sec 2(d) as follows:

"2(d) 'brain stem death' means the stage at which all functions of the brain-stem have permanently and irreversibly ceased and is so certified under subsection (b) of section 3."

This aspect of 'brain stem death' was first mentioned by Thomas J, in the context of withdrawal of artificial respiration and nutrition in Auckland Area Health Board vs. Attorney General: 1993(1) NZLR 235 and his judgment received praise from the House of Lords in Airedale NHS vs. Bland: 1993(1) All ER 821 (HL).

The House of Lords stated in Airedale that a patient may be unconscious, unable to see or hear or speak or have any sensory capacity but as long as the brain-stem, which controls the reflective functions of the body

is able to make the heartbeat and allow breathing to go on and digestion to take place, the person is not considered to be clinically dead. In the eyes of the medical world and of the law, a person is not clinically dead as long as the brain-stem retains its functions. A person may be alive, yet it may be a case of a 'living death' or 'ventilated corpse'.

As a result of developments in modern medicine and technology, a person who is unconscious and is on the verge of death but whose brain-stem has not become dead, but who is close to death, can be kept alive by artificial respiration and nutrition. Ventilators are used for providing artificial respiration and food can be sent into the body through the mouth, nose or other procedures and the body can be kept alive. Doctors no longer associate death exclusively with breathing and heartbeat and it has come to be accepted that death occurs when the brain and in particular the brain stem has been destroyed (See Prof. Ian Kennedy's paper 'Switching off Life Support Medicine: The Legal Implications' (Reprinted in 'Treat Me Right', Essay in Medical Law and Ethics (1988)(pp 351-392).

In USA, in McKay vs. Bugstedt: (1990) 801 P. ed. 617 (Nev Sup. Ct) Kenneth, aged 31 years, who was suffering from tetraplegia from the age of 10 wanted to be released from being artificially kept alive by life sustaining device of respirator. Justice Steffen said (at p 5):

“One of the verities of human experience is that all life will eventually end in death. As the seasons of life progress through spring, summer and fall, to the winter of our years, the expression unknown to youth is often heard evincing the wish to one might pass

away in the midst of a peaceful sleep. It would appear, however, that as the scientific community continues to increase human longevity and promote ‘the greying of America’, prospects for slipping away during peaceful slumber are decreasing. And for significant number of citizens, like Kenneth, misfortune may rob life of much of its quality long before the onset of winter.”

(quoted in Ms B vs. An NHS Hospital Trust: 2002 EWHC 429 by Dame Butler-Sloss, P of Family Court)

The Supreme Court of Arizona in Rasmussen vs. Fleming (1987) 154 Ariz 207 stated in a beautiful passage as follows:

“Not long ago, the realms of life and death were delineated by a bright line. Now this line is blurred by wondrous advances in medical technology – advances that until recent years were only ideas conceivable by such science fiction visionaries as Jules Verne and H.G. Wells. Medical technology has entered a twilight zone of suspended animation where death commences while life, in some form, continues. Some patients, however, want no part of a life sustained only by medical technology. Instead, they prefer a plan of medical treatment that allows nature to take its course and permits them to die in dignity.”

(quoted by Justice O’Flaherty of the Ireland Supreme Court in Ward of Court, Re a : (1995) ILRM 401)

In the light of these developments, legal, moral and ethical issues have arisen as to whether a person who is under ventilator and artificial nutrition should be kept alive for all time to come till the brain-stem

collapses or whether, in circumstances where an informed body of medical opinion states that there are no chances of the patient's recovery, the artificial support systems can be stopped. If that is done, can the doctors be held guilty of murder or abetment of suicide? These questions have been raised and decided in several countries and broad principles have been laid down. The case law in this behalf has been set out in Chapters II to V. In this chapter, we propose to summarise the principles under various headings.

(2) Euthanasia and Assisted Suicide are and continue to be criminal offences in India but not withdrawal of life support systems, under certain circumstances.:

This aspect has been referred to in some measure in the Introductory Chapter (Chapter I). We propose to go into some more detail.

(A) 'Euthanasia' is defined generally as an act of killing somebody painlessly, especially for relieving the suffering of a person from incurable illness. This is also called 'mercy killing'. The acts constituting Euthanasia may be attributed to any person, including doctors. Euthanasia is an offence in almost all countries. We shall here once again repeat what we stated in Chapter I.

'Euthanasia' which is illegal in India and in several countries, is divided into four categories. (1) passive voluntary euthanasia; (2) Active voluntary Euthanasia, (3) passive involuntary euthanasia; (4) active involuntary euthanasia and (5) Active non-voluntary euthanasia. The word 'voluntary' denotes a voluntary action of the patient himself. The word

‘active’ means the positive act of another person. The word ‘passive’ means an omission of another person which results in a patient’s death.

We shall refer in some detail about these five categories of Euthanasia..

- (1) Passive Voluntary Euthanasia: Here the medical treatment is withdrawn or withheld from a patient, at the patient’s request, in order to end the patient’s life. The word ‘passive’ denotes that there will be ‘omission’ by another person to take measures to prolong a patient’s life. ‘Voluntary’ means it is the patient’s express wish based on his informed consent, to refuse life prolong treatment.
- (2) Active Voluntary Euthanasia: Here, it is ‘active’ in the sense that another person takes action. It may be the patient’s desire for a lethal injection be given to him by another person and that decision is a conscious and rational decision. It is not a case of omission to get the treatment but a positive act. It is ‘voluntary’ because it is done with the patient’s express and informed consent.
- (3) Passive involuntary Euthanasia: It is a situation where medical treatment is withdrawn or withheld or is refused by another person in order to end the life of the patient but it is not voluntary as in the categories (1) and (2) above. It is ‘involuntary’ as it is done not at the instance of the patient but at the instance of the doctor or others. It is cessation of life-prolonging treatment to a conscious and rational person but not against his will. (This is based on

intention of the said third party and is different from ‘withdrawal of life support’, where there is no such intention to kill).

(4) Active involuntary Euthanasia: Here there is a positive or active medical intervention to end the patient’s life by a doctor or other persons. It is not at the patient’s request. Lethal injection is administered to a conscious and rational patient. This is pure ‘Euthanasia’ in the absolute sense.

(5) Active Non-voluntary Euthanasia: Euthanasia performed on a person who is incompetent and therefore not capable of giving consent.

(B) ‘Assisted Suicide’ is different from Euthanasia. It is basically ‘suicide’ because it is an act of the patient himself who puts an end to his life, while Euthanasia is always the act or omission of a third party. The patient here, however, seeks the assistance of a doctor to suggest and give him drugs which he can administer to himself in order to commit suicide. In a way, it may amount to ‘abetment’ of suicide. In ‘assisted suicide’ the doctor actively assists the patient and gives him the medicines which enable the patient to use it to commit suicide. The patient wants to commit suicide because he is unable to bear the pain and suffering.

In Euthanasia, in particular, in active involuntary euthanasia, the doctor injects the patient with a lethal dosage of medicine but in assisted suicide, the doctor prescribes the lethal dose to the patient and the patient takes it or administers it to himself. In both, the ‘intention’ element is important.

Passive Involuntary Euthanasia may appear to be close to ‘withdrawal of life support system’ but, as pointed by Sopinke J in Rodriguez vs. British Columbia Attorney General 1993(3) SCR 519, the difference is one of intention. In the former, the person (who may also be a doctor) removes the life support system of a patient, without the latter’s consent, but with an intention to kill him. But in the case of ‘withdrawal of life support system’ by a doctor in respect of an incompetent person, the withdrawal is made as being in the best interests of the patient, as accepted by a body of medical experts, and not with an intention to kill the patient. Hence it is not ‘Passive Involuntary Euthanasia’, and not an offence.

In India, Euthanasia and Assisted Suicide are and will continue to be unlawful.

Euthanasia however permitted in a few countries:

Only one or two States across the world have legalized Euthanasia or Assisted Suicide. Netherlands became the first country to legalise Euthanasia on April 10, 2001. Active Euthanasia and assisted suicide became part of Dutch medical procedures, though controlled by regulations and limitations. The law there gives importance to individual autonomy and freedom of choice when faced with the prospect of a life marked by suffering or deprived of hope. The legislature in those countries allows patients experiencing unbearable suffering to request euthanasia, and doctors who carry out such mercy killing are to be free from threats of prosecution, provided they have followed the strict procedure. Request to die must be voluntary and after full consideration, and doctor and patient

must be convinced that there is no other solution. A second medical opinion must be obtained and life must be ended in a medically appropriate way.

Belgium soon followed Netherlands by enacting a law w.e.f. 23<sup>rd</sup> September, 2002, permitting Euthanasia. While the Criminal Code remained the same, euthanasia is permitted subject to prescribed conditions. Euthanasia is described under the new law as ‘an act on purpose, performed by a third person, in order to end the life of a person who has requested for this act’. (i.e. it is voluntary active euthanasia). Under the law, only a doctor is permitted to perform euthanasia. Euthanasia is permitted when:

- (i) the patient is an adult or an emancipated minor, capable and conscious at the time of his/her request;
- (ii) the request is made voluntarily, is well thought out and reiterated, and is not the result of outside pressure;
- (iii) the patient is in a hopeless medical condition and he complains of constant and unbearable physical or mental pain which cannot be relieved, and
- (iv) he or she has complied with the conditions prescribed by the new law.

There is a long list of obligations of the doctor in regard to what the parties should be informed, and it is stated that patient's will must be free, the doctor must be sure about the suffering, a second independent doctor must be consulted, there must be discussion with family members and the doctor must even consult a psychiatrist. The physician has to declare his decision

before a federal commission composed of eight physicians, four jurists, and four others.

The Northern Territory in Australia made a law for voluntary euthanasia in 1996 but the same became unenforceable after the Federal Parliament passed the Rights of Terminally Ill Act, 1998 on 27<sup>th</sup> March, 1998.

Assisted suicide permitted in Oregon:

Oregon in USA passed the Death With Dignity Act, 1994 by which it legalized 'assisted suicide'. A patient could request for a prescription from an attending physician that the patient has an incurable and irreversible disease and that he may die in six months, within reasonable medical judgment. The request must be voluntary. The patients could be referred to counseling also. A second consulting physician must examine and confirm the attending physician's conclusions. The doctors will then prescribe a lethal dose of medicine. Assisted Suicide is also legalized in Netherlands, as stated earlier.

Barring then a few countries or States, there is clear jurisprudence that euthanasia or assisted suicide is not permissible in almost all countries.

In some countries like UK, attempt to suicide has been decriminalized but abetment of suicide remains an offence. In India, attempt to suicide and abetment of suicide are both offences under ss 309 and 306 of the Indian Penal Code, 1860 respectively

(C) Withdrawal of Life support systems is not an offence under certain circumstances

As stated in Chapter 1, and in this Chapter, ‘withdrawal of life support systems’ is different for ‘Euthanasia’ or ‘Assisted Suicide’, we have already stated that with advances in science and technology, it is possible to prolong life by use of ventilator and artificial nutrition. In the case of patients with serious diseases or in last stages of a disease, where a body of medical experts is of opinion that the prolongation of life serves no purpose and there are no chances of recovery, the doctors have no duty in law to merely prolong life. This principle is now accepted in all countries as part of the common law. If, in such cases, the treatment is withheld or withdrawn, and the patient is left to nature or the body is left to nature, there is no criminal or civil liability in as much as there is no ‘duty’ in common law, to keep a person alive if informed medical opinion is that there are absolutely no chances of survival.

Withholding or withdrawing life support is today permitted in most countries, in certain circumstances, on the ground that it is lawful for the doctors or hospitals to do so. Courts in several countries grant declarations in individual cases that such withholding or withdrawal is lawful. The various principles governing withdrawal or withholding life support systems will be discussed under the various headings herein below.

Our Supreme Court in Gian Kaur’s case 1996 (2) SCC 648 clearly held that euthanasia and assisted suicide are not lawful in our country. The court, however, referred to the principles laid down by the House of Lords in Airedale 1993(1) All ER 821 (HL) where the House of Lords accepted that withdrawal of life supporting systems on the basis of informed medical opinion, would be lawful because such withdrawal would only allow the patient who is beyond recovery to die a normal death, where there is no

longer any duty to prolong life. Thus, it is accepted that this is different from euthanasia and assisted suicide. It is not necessary to expressly provide in the proposed Bill that Euthanasia and Assisted Suicide are not lawful because that is the law, as settled by the Supreme Court in Gian Kaur.

But, it is necessary to make a provision that withholding life support system in terminally ill patients will be treated as 'lawful'.

- 3) Adult patients' right of self determination and right to refuse treatment is binding on doctors if based on informed consent
  - (a) Competent patients' informed decision to have life support system, withheld or withdrawn when he becomes terminally ill, is binding on doctors in certain circumstances:

It is, however, settled that if a competent adult patient wants life support systems not to be withheld or withdrawn, that decision is binding on the doctors. However, if a patient suggests a particular form of medical treatment be administered to him which the doctors think is not appropriate, then the doctors, if they do not follow the directive of the patient, they are not guilty of any offence or wrong. If a competent patient wants life support system to be withheld or withdrawn, it is binding on the doctors unless they come to the conclusion that the patient's decision is not an 'informed decision' (As to what is an 'informed decision' we shall explain later). In such cases, the doctor has to take a decision in the 'best interests' of the patient.

- (b) Incompetent patients: doctors to take decision for withholding or withdrawing treatment if it is in best interests of patient:

If the patient is incompetent and it is a fit case where, in the best interests of the patient, the life support system should be discontinued, if it is not discontinued, it may amount to battery. It was so observed in Airedale.

It is a well settled principle at common law that a patient has a right to accept medical treatment or refuse it. This is called the principle of self-determination.

In Airedale: 1993(1) All ER 821 (HL), Lord Goff of Chiveley stated that “it is established that the principle of self determination requires respect must be given to the wishes of the patient, so that if any adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged,” it shall be obeyed. The doctors “must give effect to his wishes even though they do not consider it to be in the best interests to do so.” This principle was first stated by Justice Cordozo in Schloendorff vs. Society of New York Hospital: (1914) 211 NY 125. It has since been accepted in almost all countries.

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Lord Goff further stated that “there is nevertheless no absolute obligation upon a doctor who has the patient in his care to prolong his life, regardless of circumstances. Indeed, it would be most startling, and could lead to the most adverse and cruel effect upon patient, if any such absolute rule were held to exist. It is scarcely consistent with primacy given to the principle of self-determination in those cases in which the patient of sound mind has declined to give his consent.”

Lord President (Lord Hope) of the Court of Sessions Inner House, in Law Hospital NHS Trust vs. Lord Advocate (Scotland): 1996 SLT 848 stated that where the patient was of full age and capable of understanding and was able to consent to the procedures if medical advice stated that the treatment was for his or her benefit, a patient could refuse treatment on the basis of the right to self-determination.

In Re T (Adult: refusal of medical treatment): 1992(4) All ER 649, the Court held that ‘every adult had the right and capacity to decide whether he or she would accept medical treatment even at the risk of permanent injury to health or premature death, and regardless of whether the reasons for refusal were rational or irrational, or were unknown or non-existent. But, where the decision to refuse was taken by a person who was not in a proper state of mind or did so under the influence of another person, then it may not bind the doctor. In Re T, the patient’s decision not to receive blood transfusion after a caesarian operation was based more upon the influence of her mother who belonged to the sect called Jehovah’s witnesses and was held not binding on the doctors.

In Canada, in Malette vs. Shulman (1990) 72 OR (2d) p 417 (Ontario Court of Appeal) Robins JA stated (at p 432):

“The issue here is the freedom of the patient as an individual to exercise her right to refuse treatment and accept the consequences of her own decision. Competent adults, as I have sought to demonstrate, are generally at liberty to refuse medical treatment even at the risk of death. The right to determine what shall be done with one’s body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matter affecting this right should, in my opinion, be accorded very high priority.”

#### The C-Test and ‘competency’

In Re C (adult: refusal of medical treatment) 1994 (1) All ER 819, the patient was suffering from schizophrenia, developed gangrene and doctors opined that his leg below knee be amputated. The patient refused. The hospital moved the Court for directions.

Thorpe J referred to what is now known as the C-Test-, that the patient must have the ‘competency i.e. the capacity to understand and decide the medical opinion. But where his faculties are reduced on account of his chronic illness and he had not sufficiently understood his state and the medical opinion, his refusal is not binding and the doctors could approach the court for directions. The C-test deals with ‘competency’ and requires that the ‘patient comprehended and retained information as to the proposed treatment, had believed it and had weighed it in the balance when making a choice’.

On facts, it was however held, that the patient's faculties were not so impaired by schizophrenia and that the presumption in favour of self-determination was not displaced. Reference was made to Re T (adult: refusal of medical treatment) 1992 (4) All ER 649 and to Airedale: 1993 (1) All ER 821 (HL).

In Re MB (Medical Treatment): 1997 (2) FLR 424, Dame Butler-Sloss, was dealing with a case where a lady refused caesarian operation while doctors wanted to perform it and save the foetus. The patient had 'needle phobia'. Later the patient agreed but refused anaesthesia at 9 PM on 18.2.97. The local health authority applied to the Court at 9.25 PM. Hollis J granted permission. The decision was confirmed in Appeal.

In the Court of Appeal, Butler-Sloss LJ stated that a patient's consent is necessary for invasive medical treatment and that a mentally competent person was entitled to refuse medical treatment, whether for good or rational or even for irrational reasons or for no reasons at all, even where that decision might lead to his death. The only situation in which it is lawful for the doctors to intervene was where 'it is believed that the adult patient lacked the capacity to decide and the treatment was in the patient's best interests. The court did not have to take into account the interests of the unborn child at risk from refusal of a competent mother to consent for medical intervention. Of course, in situations of grave urgency, decision can be taken by Court as in Re F (Mental Patient: Sterilisation) 1990 (2) AC 1.

The Court of Appeal held that the lady had a needle phobia and was in panic and not capable of taking a decision and hence was to be treated as 'temporarily incompetent'. Caesarian operation allowed by Hollis J was affirmed. The operation was in best of medical interests of the patient. The Court of Appeal approved the principles laid down by Lord Donaldson in Re T (An Adult) (Refusal of Medical Treatment): 1992 (4) All ER 649; Re T (An Adult: Consent to Medical Treatment): 1992 (2) FCR 458 (case of pregnant lady involved in car accident who required blood transfusion) and by Justice Thorpe in Re C (Refusal of Medical Treatment): 1994 (1) All ER 819.

Butler-Sloss LJ considered these cases again in Tameside and Glossop Acute Services Trust v. CH: 1996 (1) FLR 762. Johnson J referred to these principles in Norform and Norwich Health Care (NHS) Trust v. W: 1996 (2) FLR 613 – namely the C-Test which required a competent adult and what the doctors felt was in best interests.

In Re L, Kinkwood J (unreported Judgment dated 5<sup>th</sup> Dec. 1996) referred to in Re MB: 1997(2) FLR 426 held that the patient had needle phobia and was not competent to refuse.

In Ms B v. An NHS Hospital Trust: 2002 EWHC 429, Dame Butler-Sloss (P) of Family Court stated that the principle of 'autonomy' permitted patients to refuse treatment. She referred to a large number of cases including Cruzan v. Director (1990) (110 S.Ct. 2841) decided in the US Supreme Court when it said:

“No right is held more sacred, or is more carefully guarded ... than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”

The patient was wavering but the Court held on facts, that the patient was competent. Ten guidelines were laid down to judge competence. They are as follows:

“(i)There is a presumption that a patient has the mental capacity to make decisions whether to consent to or refuse medical or surgical treatment offered to him/her.

(ii)If mental capacity is not in issue and the patient, having been given the relevant information and offered the available options, chose to refuse the treatment, that decision has to be respected by the doctors. Considerations that the best interests of the patient would indicate that the decision should be to consent to treatment are irrelevant.

(iii)If there is concern or doubt about the mental capacity of the patient, that doubt should be resolved as soon as possible, by doctors within the hospital or NHS Trust or by other normal medical procedures.

(iv)In the meantime, while the question of capacity is being resolved, the patient must, of course, be cared for in accordance with the judgment of the doctors as to the patient’s best interests.

(v) If there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision.

(vi) In the rare case where disagreement still exists about competence, it is of the utmost importance that the patient is fully informed of the steps being taken and made a part of the process. If the option of enlisting independent outside expertise is being considered, the doctor should discuss this with the patient so that any referral to a doctor outside the hospital would be, if possible, on a joint basis with the aim of helping both sides to resolve the disagreement. It may be crucial to the prospects of a good outcome that the patient is involved before the referral is made and feels equally engaged in the process.

(vii) If the hospital is faced with a dilemma which the doctors do not know how to resolve, it must be recognized and further steps taken as a matter of priority. Those in charge must not allow a situation of deadlock or drift to occur.

(viii) If there is no disagreement about competence but the doctors are for any reason unable to carry out the wishes of the patient, their duty is to find other doctors who will do so.

(ix) If all appropriate steps to seek independent assistance from medical experts outside the hospital have failed, the NHS Hospital Trust should not hesitate to make an application to the High Court or seek the advice of the Official Solicitor.

(x) The treating clinicians and the hospital should always have in mind that a seriously physically disabled patient who is mentally competent has the same right to personal autonomy and to make decisions as any other person with mental capacity.

In GMC v. Burke: (2005) EWCA (Civ) 1003 (CA), Lord Phillips of Worth Matravers stated that autonomy and self determination ‘do not entitle the patient to insist on receiving a particular medical treatment regardless of nature of the treatment. Insofar as a doctor has a legal objection to provide treatment, this cannot be founded simply upon the fact that the patient demands it. The source of duty is elsewhere’ (i.e. best interest).

Summarising the position, while patient’s right to refuse or consent to medical treatment is fundamental and is binding on the doctors however rational or irrational it may be, but the said principle applies only where the patient is competent i.e. able to balance the advantages and disadvantages and mentally in a position to take a decision and is able to take an ‘informed decision’. If he is not competent or not mentally in a position to take an informed decision, his refusal or consent is not binding on the doctors and if

they take a decision which is in the best interests of the patient, it is lawful. A patient cannot also compel a doctor to give him a particular line of treatment for it is for the doctors what treatment is necessary in the best interests of the patient. These aspects are proposed to be brought into proposed Bill.

(4) Giving invasive medical treatment contrary to a patient's will amounts to battery or in some cases, may amount to murder:

This issue is our off-shoot of the issue discussed under (3) above. Under (3), we have referred to the right of self-determination of a patient who is competent and who is in a mental frame to take an informed decision. We have also referred to the exceptional cases where the patient's view will not be binding on the doctors, namely, where the patient is not competent after weighing and balancing the advantages and disadvantages of the treatment or where even if competent, his decision is not an informed decision. In that event, the doctors can take a decision keeping in mind what is in the patient's best interests.

Under the present heading, we are considering the cases of a competent adult who is fit mentally to take an informed decision to refuse medical treatment and as to what will be the consequences if the doctors give invasive treatment against the will of the patient.

It is now well-settled that giving invasive medical treatment to a patient against his will, will amount to battery and in some cases, even to

murder – if it does not fall within the exception referred to under (3). It is so held in Airedale.

In English law, actual infliction of bodily injury is called ‘battery’. Under sec. 319 of the Indian Penal Code, 1860, whoever ‘causes bodily pain, disease or infirmity to any person is said to cause hurt’.

In Airedale: 1993 (1) All ER 821 (HL), Lord Keith of Kinkel observed that the giving of medical treatment will be unlawful both under the law of torts and criminal law of battery, where the patient has refused consent or where patient’s consent has not been obtained. He referred to In re F (Mental Patient: Sterilisation): 1990 (2) AC 1. In the same case, Lord Browne-Wilkinson stated that any treatment given by a doctor which is invasive (i.e. involves any interference with the physical integrity of the patient) is unlawful unless done with the consent of the patient. It constitutes the crime of battery and the tort of trespass to the person.

Thus the principle is clear enough that invasive treatment amounts to battery if given against a patient’s will. In some cases, it may even amount to murder. As the principle is well settled, no provision is necessary in the proposed Bill in this behalf.

(5) Advance Directives (Living Wills); and Powers of Attorney in favour of surrogates to be void in India, as a matter of public policy:

In several countries, it is permissible for a competent adult to execute an Advance Directive (Living Will) as to whether he or she should or

should not be given medical treatment when he or she is terminally ill and not in a position to take a medical decision.

In US, there is also a further statutorily permitted procedure for executing a Medical Power Of Attorney in favour of a close relative or friend (surrogate) to take a medical decision in such situations. These are called decisions of surrogates. US has built up a large case law on surrogates also apart from Advance Directives (Living Wills) because both these systems are permitted in that country. Needless to say, that both have created a number of complex problems in practice.

But in UK, the House of Lords in Airedale 1993(1) All ER 821 (HL) has rejected the Medical Power Of Attorney procedure and said it is not recognized in UK. In Ireland also O'Haherty did not approve powers of attorney in Ward of Court, Re a: (1995) 1 LRM 401, in the particular case.

In U.K., advance directives are permissible and may or may not be binding (as explained below), but procedure by way of medical powers of attorney delegating authority to surrogates to take medical decisions is not accepted.

(A) Advance Directive (create complex problems):

So far as Advance Directives (Living Wills) are concerned, a patient might give or refuse his consent to invasive medical treatment at or before the time immediately before such treatment or he could, even much earlier, decide in writing that such and such treatment should or should not be

given. It can also be oral. We are not dealing with such directions given at the time of giving or omitting to give invasive treatment. We are here dealing with directives given at a distant point of time which are called 'Advance Directives'.

We shall refer to complicated factual issues which Advance Directives have brought in U.K.

(1) In Airedale Lord Goff stated that "it has been held that a patient of sound mind may, if properly informed, require that life support should be discontinued (Nancy B v. Hotel-Dieu de Quebec: (1992) 86 DLR (4th) 385). Moreover, the same principle applies when the patient's refusal to give consent has been expressed at an earlier date long before he had become unconscious or he became incapable of communicating it. In such cases, it is necessary to take notice of such prior directives and are applicable in the circumstances which have subsequently occurred. (Re T (Adult): Refusal of Treatment) 1992 (3) WLR 782 = 1992 (4) All ER 649. If a patient had decided not to have medical treatment, the patient is not guilty of suicide and the doctors are not guilty of murder or abetment of suicide.

(2) In Re T above mentioned, which was referred to in Airedale, the patient's mother was a Jehovah's witness and the refusal of the patient for treatment was not accepted by the trial Judge and the Appellate Court because it was not an informed decision and had been influenced by her mother.

In that case, the Court of Appeal held that sometimes it will be advantageous to the doctors to consult the patient's close relatives so that they could give information as to whether the patient was conscious when the advance directive was given.

(3) In Re C: 1994 (1) All ER 819, it was held that the previously expressed view of a patient will be an important component in the decision of the doctors and the Court.

(4) HE vs. Hospital NHS and Anr: 2003 EWHC 1017 is an important decision by Munby J on Advance Directives and their continued validity. We get the hint from Airedale that the doctors or Court must see if an earlier directive continues to be applicable or be valid in the circumstances that might occur several years later.

In HE, the patient was born in a Muslim family, her parents separated, her mother became a Jehovah's witness (who did not agree for blood-transfusion). The patient suffered a heart problem, executed an Advance Medical Directive on 13.2.2001, witnessed by two Church Ministers. On 20.11.2003, she became ill and surgery was felt necessary by the doctors but blood-transfusion was a problem because of the 2 year old Advance Directive. She was sedated on 20.4.2003 and while her mother and brother opposed blood transfusion, her father, who continued to be a Muslim applied to the Court on 2.5.2003 for permission to give blood transfusion. Munby J permitted blood transfusion on 2.5.2003 when he heard the case and gave judgment on 7.5.2003 notwithstanding the Advance Directive.

Munby J initially referred to the efficacy of the Advance Directive as follows:

- (1) A competent adult patient has an absolute right to refuse consent to any medical treatment or invasive procedure, whether the reasons are rational, irrational, unknown or non-existent, and even if the result of refusal is the certainty of death. He agreed with Prof. Andrew Grubb's observation (see 2002 Med L Rev 201 at 203) that: 'English law could not be clearer. A competent adult patient once properly informed, has the unassailable right to refuse any or all medical treatment or care'.
- (2) Consistently with this, a competent adult patient's anticipatory refusal of consent (a so-called advance-directive or a living-will) remains binding and effective notwithstanding that the patient has subsequently become and remained incompetent.
- (iii) An adult is presumed to have capacity, so the burden of proof is on those who seek to rebut the presumption and who assert a lack of capacity."

As to whether an Advance Directive given earlier remains applicable and valid later, the matter is one of proof. He laid down the principles applicable to the burden of proof and to the standard of proof, as follows:

- (i) While there is a presumption in favour of capacity and the burden to prove incapacity is on those who dispute capacity, there is another burden where there is an advance directive. This burden is on those who rely on the advance directive to

prove its existence, its continuing validity and applicability.

If there is doubt, that doubt falls to be resolved in favour of preservation of life.

- (ii) As to standard of proof of the advance directive, it must be clear and convincing, based on balance of probabilities as in civil cases. The more extreme the gravity of the matter in issue, the stronger and more cogent the evidence must be. When life is at stake evidence must be scrutinized with special care. (In re H. (Minors)(Sexual Abuse: Standard of Proof) 1996 AC 563 and dictum of Ungood – Thomas J in Re Dellow’s Will Trusts: 1964 (1) WLR 451 (455). The continuing validity and applicability of the advance directive must be established by clear convincing and inherently reliable evidence.
- (iii) Depending upon the lapse of time and the known changes in the patient’s circumstances during that time, the validity of the advance directive has to be examined. See In re T: (Adult: Refusal of Treatment) 1993 Fam 95, Lord Donaldson MR (p 103) where he referred to two ‘ys’ for the validity of an advance directive or anticipatory choice.

Munby J stated that there is:

“... a conflict between two interests, that of the patient and that of the society in which he lives. The patient’s interest consists of his right to self-determination – his right to live his own life, how he wishes, even if it will damage his health or lead to his premature death. Society’s interest is in upholding the concept that all human life is

sacred and that it should be preserved if at all possible. It is well-established that in the ultimate, the right of the individual is paramount. But this merely shifts the problem where the conflict occurs and calls for a very careful examination of whether, and if so the way in which, the individual is exercising that right. In case of doubt, that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, he must do so in clear terms".

Munby J referred to Lord Donaldson's statement (at p 114) that an 'advance directive' 'may have been based upon an assumption', which is falsified, in which case, it is necessary to examine the assumption. Lord Donaldson said:

"If... the assumption upon which it is based is falsified, the refusal ceases to be effective. The doctors are then faced with a situation in which the patient has made no decision and he by then being unable to decide for himself, they have both the right and the duty to treat him in accordance with what in the exercise of their clinical judgment they consider to be in his best interests."

Munby J referred to Francis & Johnston, 'Medical treatment: Decisions and the Law' (Ed 2001) (para 1.29) that a patient's consent to treatment will not survive a material change of circumstances. In the same way, Munby J stated that, a patient's anticipatory refusal to treatment will not survive a material change of circumstances. He quoted Lord Goff in Bland (at p 864) where it is stated that an advance directive must be considered with 'especial care'. "... Especial care may be necessary to ensure that the prior

refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred.”

Munby J also referred to what Hughes J said in Re AK: 2001(1) FLR 129 (p 134):

“... in the case of an adult patient of full capacity, his refusal to consent to treatment or care must in law be observed. It is clear that in an emergency, a doctor is entitled in law to treat by invasive means, if necessary, a patient who, by reason of the emergency, is unable to consent, on the ground that the consent can, in those circumstances, be assumed. It is, however, also clearly the law that the doctors are not entitled so to act if it is known that the patient, provided he was of sound mind and full capacity, has let it be known that he does not consent and that such treatment is against his wishes. To this extent an advance indication of the wishes of a patient of full capacity and sound mind are effective. Care will of course have to be taken to ensure that such anticipatory declarations of wishes still represent the wishes of the patient. Care must be taken to investigate how long ago the expression of wishes was made. Care must be taken to investigate with what knowledge the expression of wishes was made. All the circumstances in which the expression of wishes was given will, of course, have to be investigated.”

Thus, Advance Directive can also create complex legal and factual issues.

(5) In NHS Trust v. T: 2004 EWHC 1279, Charles J was dealing with a lady who had psychological problems and would cut herself for blood-

letting. She therefore required blood transfusion but she executed an Advance Directive (attested by a lawyer) refusing blood transfusion ‘unless when she is subject to compulsory treatment under the Mental Health Act, 1983’. She gave reasons that blood given was evil and if blood given mixes with hers, the entire blood becomes evil. She stated she was mentally competent while writing the Advance Directive.

When she was in a collapsing state on 8.4.2004, Pauffley J by her order dated 9.4.2004, permitted blood transfusion using minimum force. She recovered on 13.4.2004 and on 16<sup>th</sup> her lawyer raised objections to the blood transfusion.

Charles J held that the lady lacked capacity when she executed the Advance Directive.

(6) More recently in GMC v. Burke: (2005) EWCA (Civ) 1003 (CA), Lord Phillips stated that to keep a PVS (permanent vegetative state) patient alive merely because of his advance directive, will violate the Mental Capacity Act, 2005. He said that under sec. 26 of this Act, though compliance with reference to advance directive is necessary, still sec. 4 does no more than require this (the Advance Directive) to be taken into consideration when considering what is in the best interests of a patient.

(7) Obviously, the Act of 2005 has made a change in the law by stating that in the case of patients lacking mental capacity, the Advance Directive is only a matter to be taken into account – but not implicitly obeyed – while considering the best interests of a patient.

From the above, it is clear that even ‘Advance Directives’ have created serious factual and legal issues in U.K.

Question arises whether Advance Directives (Living will) should be allowed legal sanctity in our country?

It is true that there is an inherent right of self-determination under which an Advance Directive can be given, as a matter of common law. It can be in writing or oral. If the patient becomes incompetent at a later stage on account of illness, the doctors will be bound to go by the Advance Directive unless such directive has become inapplicable or invalid due to passage of time or change in circumstances, advances in medicine and technology, etc. Question is, if such a right has given rise to serious issues of law and fact in U.K., whether Advance Directives should be allowed to be valid in our country.

In our view, if an Advance Directive can also be oral, it can create serious problems of proof and may also lead to serious abuse.

Coming to Advance Directives in writing, we have seen the legal position. It must be proved that the Advance Directive was based upon informed consent of the patient, with knowledge of state of his or her illness and of the medicines or medical technology available. This again requires oral evidence to be adduced. Then again, due to change in circumstances or on account of delay or developments in medicine/technology which have improved and which give scope for living longer without pain or suffering,

the earlier Directive may have been rendered inapplicable or invalid on account of latter circumstances. There may also be oral evidence of withdrawal of a written or oral directive. This can also create serious problems of proof.

In our view, there is not only scope for contentious and complex issues of fact and law being raised in every case relating to oral or written Advance Directives, but in a country where there is considerable illiteracy and lack of knowledge of developments in medicine and technology, there is scope for Advance Directives being based on wrong assumptions or requiring proof that they were, as a fact, made or that they continue to be applicable and valid or have not been withdrawn and there is large scope for abuse and litigation. A lot of evidence will be oral and may be conflicting. Doctor's consequential actions can give rise to any amount of litigation.

In our view, as a matter of public policy in India, Advance Directives oral or written are controversial and can lead to mischief and should be made legally ineffective, overriding the common law right.

(A) Medical Powers of Attorney:

Equally, it is in our view, not desirable to make a statute, execution of "medical powers of attorney" enabling surrogates to take medical decisions on behalf of the patient. Power of Attorney can create too many medical and legal issues and for the reasons for which they have been rejected even in U.K., they are not suitable even for our country. Even in US, they have created lot of legal problems and a large amount of case law. In regard to

medical powers of attorney, Lord Goff in Airedale, 1993 (1) All ER 821 rejected the delegation of decision making to power of attorney agents (see In re Quinian : (1976) 355 A. 2d 647 and Superintendent of Belchertown State School v. Saikewicz: 370 NE 2d 417. He stated:

“.... I do not consider that any such test forms of English law in relation to incompetent adults on whose behalf nobody has power to consent to medical treatment. Certainly in In re F: (1990) (2) HCI, your Lordship’s House adopted a straightforward test of best interests of the patient.”

We are, therefore, of the view that both Advance Directives and Medical Powers of Attorney should not be valid in our country on ground of public policy. A provision is proposed in this behalf to make them void.

(6) State’s interest in protecting life and principle of sanctity of life are not absolute: Indian Penal Code affirms this view.

It is the law in all countries that the State is interested in protecting life and treats life as sacrosanct. Right to life includes right to live with dignity. Our Supreme Court said this in several cases while interpreting the meaning of the words ‘right to life’ in Art. 21 of the Constitution. However, in all countries life is protected and the Penal codes which are enacted contain a long list of criminal offences which deal with injury to the body of another person or killing of human beings. The Law of Torts also provides civil remedies for compensation for bodily injury or death. It is one of the fundamental duties of the State to take steps to preserve and

maintain the health and well-being of its citizens. The medical profession has an important role in taking care of the health of the people. The profession is regulated by professional bodies like Medical Councils.

As pointed out earlier, only in a few countries there are laws which permit voluntary termination of life. In Netherlands, there is a law made w.e.f. April 10, 2001, where Euthanasia and Assisted Suicide have been legalized; in Belgium where w.e.f. 23.9.2002, euthanasia has been legalized; the Northern Territory of Australia made a law in 1996 for making Euthanasia valid but it became unenforceable after the Federal legislature passed the Rights of Terminally Ill Act, 1998 w.e.f. 27.3.1998. In USA, Oregon alone passed the Death with Dignity Act, 1994 legalising 'Assisted Suicide'. These are exceptions.

In our country, the State prohibits 'suicide' and 'abetment of suicide'. (In some countries like UK, the suicide has been decriminalized but 'abetment of suicide' remains an offence).

As far as 'attempt to commit suicide' is concerned, sec. 309 of the Indian Penal Code, 1860 prohibits the same. It states:

“Sec. 309: Whoever attempts to commit suicide and does any act towards the commission of such offence shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both.”

(We shall deal with the question whether refusal to have medical treatment amounts to ‘attempt to suicide’, separately).

Likewise, the Penal Code in sec. 306 also states that ‘abetment of suicide’ is an offence. Sec. 306 states as follows:

“Sec 306: If any person commits suicide, whoever abets the commission of such offence, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.”

‘Abetment’ of any offence is defined in sec. 107. (We shall refer to it separately in detail when we deal with the question whether the withholding or withdrawing medical treatment amounts of abetment of suicide).

The State makes ‘murder’ an offence under sec. 302 of the Penal Code, 1860. Sec. 299 defines ‘culpable homicide’. Sec. 300 defines when ‘culpable homicide’ amounts to ‘murder’. Sec. 304 mentions about punishment for culpable homicide not amounting to murder.

Thus, the Indian Penal Code, 1860 upholds the sanctity of life in several respects.

In Ms B v. An NHS Hospital Trust: 2002 EWHC 429, Dame Elizabeth Butler-Sloss (President of Family Court) was dealing with a serious case of a lady who suffered damage to the spinal column who executed a living will for discontinuance of medical treatment if her

condition became life-threatening. The learned Judge held that the principle of sanctity of life was not absolute but that it is still the concern of the State including the judiciary. At the same time, no medical officer can be compelled to treat a patient against his wishes, even if death was imminent. The principle of sanctity of life was explained by Lord Keith and Lord Goff in Airedale.

In Nancy B v. Hotel-Diem de Quebec (1992) 86 DLR (4<sup>th</sup>) 385 where in a case before the Quebec Supreme Court, a 25 year old woman with incurable neurological disorder refused ventilation, the Court accepted her prayer to stop ventilation.

In Gian Kaur's case: 1996 (2) SCC 648, adverting to PVS patients, the Supreme Court of India quoted with approval the observations of the House of Lords in Airedale that the principle of sanctity of life is not absolute. Lord Keith stated in Airedale: “Given that existence in the persistent vegetative state is not a benefit to the patient, it remains to consider whether the principle of the sanctity of life, which is the concern of the State, and the judiciary as one of the arms of the State, to maintain, requires this House to hold that the judgment of the Court of Appeal was incorrect. In my opinion it does not. The principle is not an absolute one. It does not compel a medical practitioner on pain of criminal sanctions to treat a patient, who will die if he does not, contrary to the express wishes of the patient. It does not authorize forcible feeding of prisoners on hunger strike. It does not compel the temporary keeping alive of patients who are terminally ill where to do so would merely prolong their suffering. On the other hand, it forbids the taking of active measures to cut short the life of a

terminally ill-patient. In my judgment, it does no violence to the principle to hold that it is lawful to cease to give medical treatment and care to a PVS patient who has been in that state for over three years, considering that to do so involves invasive manipulation of the patient's body to which he has not consented and which confers no benefit upon him.

Lord Goff also stated that the 'principle of sanctity of life must yield to the principle of self-determination and for present purposes more important, the doctor's duty to act in the best interests of his patient must likewise be qualified. He also stated that there is no absolute obligation upon a doctor who has the patient in his care to prolong his life, regardless of circumstances.

In Re J (a minor: Wardship: medical treatment) 1990 (3) All ER 930, the Judge was dealing with a child who suffered brain damage and was epileptic, and who was likely to develop spastic quadriplegia, blindness and deafness if life was prolonged. He was ventilated but reventilation could make him collapse. The trial Judge refused reventilation. The Court of Appeal affirmed the judgment because reventilation would lead to the child's collapse, or even survival may be very tortuous for the child. Lord Donaldson quoted the judgment of the British Columbia Court in Re Superintendent of Family and Child Science and Dawson (1983) 145 DLR, 3d, 610. There McKenzie J of the Supreme Court of British Columbia (Canada) referred to the words of Asch J of the New York Court in Re Weberlist (1974) 360 NYS (2d) 783 (at 787) as follows:

“There is a strident cry in America to terminate the lives of other people – deemed physically or mentally defective.... Assuredly, one test of a civilization is its concern with the survival of the ‘unfittest’, a reversal of Darwin’s formulation.... In this case, the Court must decide what its ward would choose, if he were in a position to make sound judgment.”

A ward, with the type of future as was in store for J, would obviously not invite reventilation and survival having regard to the future prospect of total disability. Therefore, the State’s right of preserving life is not absolute.

In GMC v. Burke: (2005) EWCA (Civ) 1003 (CA) Lord Phillips of Worth Matravers MR stated that the Courts have accepted that where life involves an extreme degree of pain, discomfort or indignity to a patient, who is sentient but not competent and who has manifested no wish to be kept alive, that circumstance may absolve the doctors of the positive duty to keep the patient alive. Equally, the Courts have recognized that there may be no duty to keep alive a patient who is in a persistent vegetative state. Referring to Re J, he said “there are tragic cases where treatment can prolong life for an indeterminate period, but only at a cost of great suffering while life continues”.

All these show that while life is sacrosanct and the State has a duty to protect life, the principle is not absolute and there are, in reality, cases where attempts to prolong life may amount to perpetrating acute suffering on patients, and therefore in the case of incompetent patients, doctors can take decision to stop life support systems if it is in the best interests of the

patient. As to the manner of deciding what is in the ‘best interests’ of a patient; we shall be discussing that aspect separately.

No provision is necessary in the proposed Bill to state that the State’s interest in property lies or that principle of sanctity of life is not absolute.

- 7) Refusal to obtain medical treatment, in certain circumstances, does not amount to ‘attempt to commit suicide’; withholding or withdrawing medical treatment, in certain situations, does not amount to ‘abetment of suicide’ proposed to be made in Bill treat such actions as ‘justified by law’: (Indian Penal Code, 1860 considered).

This is the most important aspect on which considerable discussion will be necessary.

Under the last heading, we have referred to the broad principle that sanctity of life is not absolute and that while the State, of which judiciary is a part, is also interested in prolonging life, there are grave cases in which this principle has to be excepted.

We have referred to the patients’ right of self-determination where he or she directs at or about the time when treatment is to be given that no treatment be given to him or her when he is in a serious medical condition. Where this is done by an adult who is competent and the decision is an informed one, it is binding on the doctor. In cases where such decision of competent patients are not based on informed consent, and in the case of minors or incompetent persons or persons in a persistent vegetative state, the doctors can take medical decisions that it is not in the patients best

interests to live longer and that the life supporting systems could be withheld or withdrawn.

(i) In such situations, two questions arise. So far as the patient who is an adult and competent who refuses treatment, does it amount to ‘attempt to commit suicide’?

(ii) So far as the doctors are concerned, in the case of an adult where they obey the patient’s refusal or where in the case of competent patient whose decision to refuse treatment is not an informed one and where the patient is a minor or incompetent or a PVS they take a bona fide decision to stop artificial life support, on the basis of ‘best interests’ of the patient, question arises whether they are guilty of ‘abetment of suicide’?

Questions (i) and (ii) are answered by the decisions referred to by us in the preceding Chapters. But we shall briefly recapitulate the cases decided by our Supreme Court and other countries and summarise them.

The Supreme Court in Gian Kaur v. State of Punjab 1996 (2) SCC 648 while upholding the validity of sec. 309 of the Indian Penal Code, 1860 which speaks of ‘attempt to commit suicide’, also considered, towards the end of the judgment, the decision of the House of Lords in Airedale: 1993 (1) All ER 821 which related to a patient in a PVS state. While declaring that Euthanasia and Assisted Suicide are prohibited under our law and are not lawful, the Supreme Court dealt with persons in a vegetative state, as in Airedale, and held that sanctity of life is not absolute, and that in cases of persons in persistent vegetative state where further living is of no benefit to

the patient, there is a distinction between euthanasia (mercy killing) and cases where a patient has entered into a state close to death, a physician decides not to provide or continue to provide treatment which could or might prolong the patient's life without any possible state of revival'. These observations made by the Supreme Court, in contrasting that situation with Euthanasia and Assisted Suicide, gives a clear indication that the Supreme Court did not consider withdrawal or withholding medical treatment in such cases as offences, on par with Euthanasia. The Court also stated in Gian Kaur: 1996(2) SCC 648 after referring to Art. 21 as follows (p 660):

“A question may arise, in the context of a dying man who is terminally ill or in a persistent vegetative state that he may be permitted to terminate it by a premature extinction of his life in those circumstances. This category of cases may fall within the ambit of the ‘right to die’ with dignity as a part of ‘right to live’ with dignity, when death due to termination of natural life is certain and imminent and the process of natural death has commenced.”

This passage from Gian Kaur supports the view that stoppage of medical treatment to allow the patient to ‘die with dignity’ is part of the ‘right to life’ under Art. 21 and hence not unlawful. It is not unlawful both for the patient who wants to die by directing stoppage of treatment and it is not unlawful for the doctor either to obey a directive of a competent patient or to take such a decision in the best interests of a minor or incompetent patient. This is further clear from another passage in Gian Kaur, where the distinction is made between ‘accelerating the process of natural death’ (by

not administering treatment) and positively accelerating death by a physician who assists in a suicide, is referred to (at p.661):

“These are not cases of extinguishing life but only of accelerating conclusion of the process of natural death which has already commenced. The debate even in such cases to permit physician-assisted termination of life is inconclusive. It is sufficient to reiterate that the argument to support the view of permitting termination of life in such cases to reduce the period of suffering during the process of certain natural death is not available to interpret Art. 21 to include therein the right to curtail the natural span of life.”

The last sentence obviously refers to physician-assisted suicide, which is referred to in the previous sentence and which is not part of Art 21. But the first sentence, read with the passage at p 660, refers to the lawfulness of withdrawal of life-support of a PVS patient, which is within Art 21.

Therefore, it is clear that Gian Kaur supports the principle that withholding or withdrawing life support system to PVS patients in whose cases the process of death has started does not amount to an offence.

In Airedale, the House of Lords clearly declared by affirming the decision of the Court of Appeal that:

“despite the inability of the defendant to consent thereto, the plaintiff and the responsible attending physicians:

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

As to suicide and abetment of suicide, in such cases of lawful termination of medical treatment, Lord Goff said: “I wish to add that, in cases of this kind, there is no question of the patient having committed suicide nor, therefore, of the doctor having aided or abetted him to do so”. Lord Goff said in Airedale that the ‘omission is not a breach of duty by the doctor, because he is not obliged to continue in a hopeless case’ (quoting Prof. Glanville Williams, *Criminal Law*, 2<sup>nd</sup> Ed (1983) (p.282).

An omission will not be unlawful unless there is a breach of duty towards the patient. If there is no such duty in respect of a patient who is in dying state with no chances of recovery and, where nature is allowed to take its course, it is lawful to discontinue the treatment. It is lawful to allow a patient in a dying state to die a natural death because the competent patients want it or in the case of the incompetent patient (and the competent patient whose decision is not informed), it is in the patient’s best interests.

Lord Browne-Wilkinson pointed out (p. 881) that ‘apart from the act of removing the nasogastric tube, the mere failure to continue to do what you have previously done, is not, in any ordinary sense, to do anything

positive; on the contrary, it is by definition an omission to do what you have previously done.... If, instead of removing the nasogastric tube, it was left in place but no further nutrients were provided for the tube to convey to the patient's stomach, that would not be an act of commission". He refers to Skegg, 'Law, Ethics and Medicine' (1984) (p 169) to state (see p 881) that 'If switching off a ventilator were to be classified as a positive act, exactly the same result can be achieved by installing a time-clock which requires to be re-set every 12 hours; the failure to reset the machine could not be classified as a positive act'. He also said that the 'doctor cannot owe to the patient any duty to maintain life where that life can only be sustained by intrusive medical care to which the patient will not consent or in the case of an incompetent patient,

“if there comes a stage where the responsible doctor comes to the reasonable conclusion (which accords with the views of a responsible body of medical opinion (Bolam Test), that further continuance of an intensive life support system is not in the 'best interests' of the patient, he can no longer lawfully continue that life support system; to do so would constitute the crime of battery and the tort of trespass to the person”.

Thus, while withholding or withdrawing life support do not amount attempt to commit suicide or abetment to suicide, continuing treatment contrary to patient's wishes or where it serves no purpose and is not in the best interests of the patient, can amount to the offence of battery or the tort of trespass to the person.

Hamilton CJ of the Ireland Supreme Court stated in Ward of Court, Re a: 1995 (ILRM) 401, that

“As the process of dying is part and an ultimate consequence of life, the right to life necessarily implies the right to have nature taking course and to die a natural death.”

Thus, refusing treatment and allowing the body to die a natural death is also not an offence. In the same case, O’Flaherty J after referring to ‘right to life’ and Art 2 and 6 of the European Convention and Art 6 of the ICCPR stated:

‘This case is not about terminating a life but only to allow nature to take its course which would have happened even a short number of years ago and still in places where medical technology has not advanced so much as in this country’.

He stated that in ‘irreversible incompetents’ right to self determination also outweighs the State’s interest in preserving life, preventing suicide, protecting third party defendants of the dying patient, and preserving the ethical integrity of the medical profession.

In Scotland, in Law Hospital NHS Trust vs. Lord Advocate (Scotland): 1996 SLT 848, Lord Hope referred to Airedale. The Courts could grant a declaration that it was lawful to discontinue the treatment.

In Gillick vs. West Norfolk Wisbech Arce Health Authority: 1986 A.C. 112 (HL), it was stated that a doctor, who, in exercise of his clinical judgment gave contraceptive advice and treatment to a girl under 16 without her parents’ consent, did not commit any offence under the Sexual Offences Act, 1956 because of the bona fide exercise of clinical judgment by the doctor and it negated mens rea which is an essential ingredient of the

offence. 'Gillick test' depends on the stage of development of the child who is given the advice.

In the Siamese twins case : Re A (Children): 2000 EWCA 254, Ward LJ in the Court of Appeal summarized the principles laid down in Airedale. Then he stated that "an omission to act would nonetheless be culpable, if there was a duty to act', there was no duty if treatment was not in the best interests of the patient.

In GMC vs. Burke: (2005) EWCA (Cir) 1003(CA) Lord Philips of Worth Matravers agreed with Munby J's observations that Art 2 of the European Convention does not entitle any one to continue life-prolonging treatment where to do so would expose the patient to 'inhuman or degrading treatment', breaching Art 3. On the other hand, a withdrawal of life prolonging treatment which satisfies the exacting requirement of the common law, including a proper application of the intolerability test, and in a manner which is in all respects comparable with the patient's rights under Art 3 and Art 8, will not give rise to breach of Art 2".

But Art 2 of the European Convention would be infringed if the doctor withdrew the treatment contrary to the patient's wishes (i.e. advance directive). If English law permitted such a conduct, this would violate the country's positive obligation to enforce Art 2. The English Criminal Law would not countenance such conduct.

In Cruzan vs. Director MDH: (1990) 497 US 261 Scalia J said that omission to receive treatment to incompetent does not amount to 'suicide'. Scalia J said:

“Suicide, it is said, consists of an affirmative act to end one’s life; refusing treatment is not an affirmative act ‘causing’ death, but merely a passive acceptance of the natural process of dying. I readily acknowledge that the distinction between action and inaction has some bearing upon the legislative judgment of what ought to be prevented as suicide – though even there, it would seem to me unreasonable to draw the line precisely between action and inaction, rather than between various forms of inaction. It would not make much sense to say that one may not kill oneself by walking into the sea, but may sit on the beach until submerged by the incoming tide, or that one may not intentionally lock oneself into a cold storage locker but may refrain from coming indoors when the temperature drops below freezing. Even as a legislative matter, in other words, the intelligent line does not fall between action and inaction, but between those forms of inaction that consist of abstaining from ‘ordinary’ care and those that consist of abstaining from ‘excessive’ or ‘heroic’ measures. Unlike action vs inaction, that is not a line to be discerned by logic or legal analyses and we should not pretend that it is.”

“It is not surprising, therefore, that the early cases considering the claimed right to refuse medical treatment dismissed as specious, the nice distinction between “passively submitting to death and actively seeking it. The distinction may be merely verbal, as it would be if an adult sought death by starvation instead of a drug. If the State may

interrupt one mode of self-destruction, it may with equal authority interfere with the other. John F. Kennedy Memorial Hospital vs. Heston (1971) 58 N.J. 576; see also Application of President & Directors of Georgetown College Inc: (1964) 118 US App. DC-80: 331 F 2d 1000. The third asserted basis of distinction – that frustrating Nancy Cruzan’s wish to die in the present case requires interference with her bodily integrity – is likewise inadequate, because such interference is impermissible only if one begs the question whether refusal to undergo the treatment on her own, is suicide. It has always been lawful not only for the State, but even for private citizens to interfere with bodily integrity to prevent a felony..... That general rule has of course been applied to suicide. At Common Law, even a private person’s use of force to prevent suicide was privileged.... It is not even reasonable, much less required by the Constitution, to maintain that, although the State has the right to prevent a person from slashing his wrists, it does not have the powers to apply physical force to prevent him from doing so, nor the power, should he succeed, to apply, coercively, if necessary, medical measures to stop the flow of blood. The state-run hospital, I am certain, is not liable under 42 U.S.C. 1983 for violation of constitutional rights, nor the private hospital liable under general tort law, if, in a state where suicide is unlawful, it pumps out the stomach of a person who has intentionally taken an overdose of barbiturates, despite that person’s wishes to the contrary”.

Scalia J then deals with the dissent by Brennan & Stevens JJ and says:

“... the State has no such legitimate interest that could outweigh ‘the person’s choice to put an end to her life’..... the State must accede to her ‘particularized and intense interest in self-determination in her choice whether to continue living or die.’” For, insofar as balancing the relative interests of the State and the individual is concerned, there is nothing distinctive about accepting death through the refusal of ‘medical treatment’, as opposed to accepting it through the refusal of food, or through the failure to shut off the engine and get out of the car after parking in one’s garage after work. Suppose that Nancy Cruzan were in precisely the condition she is in today, except that she could be fed and digest food and water without artificial assistance, how is the State’s interest in keeping her alive thereby increased or her interest in deciding whether she wants to continue living reduced?”  
(emphasis supplied)

He stated that he could not agree with Brennan & Stevens that a person could make the choice of death. That view the State has not yet taken. The Constitution does not say anything on the subject.

In Canada, in Nancy B vs. Hotel Dieu de Quebec (1992) 86 DLR (4<sup>th</sup>) 385, the Dufour J of the Quebec Supreme Court said that the plaintiff’s death would be natural and would not involve homicide or suicide. He observed: “In any event, declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide.” The disease is allowed to take a natural course and “if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury”.

Sopinka J in Rodriguez vs. AG : 1993(3) SCR 519 (Canada), speaking for majority, quoted from Airedale where Lord Goff referred to the Report of the Law Reform Commission (1983) (of Canada). It was there stated that the criminal codes be amended to provide that the homicide provisions be not interpreted as requiring a physician “to undertake medical treatment against the wishes of a patient, or to continue medical treatment when such treatment ‘has become therapeutically useless’”.

In New Zealand in Auckland Area Health Board vs. AG: 1993(1) NZLR 235, Thomas J stated that if the doctor was justified in withdrawing life support, there was ‘lawful excuse’ which was a defence if any criminal action were to be taken against him. If the doctor was not under an absolute legal duty to provide or continue with life support or he had a ‘lawful excuse for discontinuing it, it may then be said that he or she had not legally caused death of the patient. Continuing medical treatment where it was fruitless was ‘only to defer the death of patient’ and nothing more. Discontinuance accords with ‘good medical practice’. Acting under principles of ‘good medical practice’ cannot make a doctor liable for any criminal offence. If the cause of death of the patient was not the criminal intent of the doctor but was based on good medical practice and if that was good for sec 151 of the NZ Crimes Act, 1961, it was also good for sec 164 which deals with the offence of ‘acceleration of death’. The withdrawal of life support is not an unlawful act for purposes of sec 160 in determining whether a homicide was culpable or not. It cannot be regarded as an unlawful act when the doctors concerned were not in breach of duty and had a lawful excuse.

## Summary

From the above principles almost uniformly laid down by the Courts in several countries, it is clear that (i) in the case of a patient who is seriously ill, but competent, his refusal, not to take medical treatment and allow nature to take its own course, it is lawful and does not amount to 'attempt to commit suicide', (ii) Likewise, (a) where doctors do not start or continue medical treatment in such cases because of such patients' refusal, they are not guilty of abetment of suicide or murder or culpable homicide and (b) if the patient is a minor or is incompetent or is in a permanent vegetative state, or (c) if the patient was competent but his decision was not an informed one, and if the doctors consider that there are no chances of recovery and that it was in the best interests of the patient that medical treatment be withheld or discontinued, the doctor's action would be lawful and they will not be guilty of any offence of abetting suicide or murder or culpable homicide.

We will be dealing with these aspects, with particular reference to the provisions of the Indian Penal Code and the Law of Torts towards the end of this Chapter. We propose a provision in the Bill that refusal for medical treatment by the patient or withdrawal or withholding treatment by doctors either on patient's instruction or the principle of best interests, will be treated as 'lawful'

8. Competent and incompetent patients 'informed decision' and best interests

We shall here refer to the distinction between ‘competent’ and ‘incompetent’ patients and as to what is meant by ‘best interests’. In the draft Bill, we propose to give definitions on the basis of decided cases. These definitions are mostly based on the C-Test evolved by Justice Thorpe in the case already referred to earlier in Re C 1994(1) All ER 819.

(1) Competent and incompetent patients

It is first necessary to define ‘incompetent patients’.

An ‘incompetent patient’ is (i) a minor or person of unsound mind or (ii) a patient who is unable, on account of pain or suffering (physical, mental or psychological) to

- (a) understand the information relevant to an informed decision about him or his medical treatment,
- (b) retain that information,
- (c) use or weigh that information as part of the process of such decision or
- (d) to treat an informed decision because of the impairment of or a disturbance in the functioning of his mind or brain
- (e) to communicate his or her informed decision (whether by speech, sign language or any other method).

In such cases, the decision will be of the medical practitioner to decide to withhold or withdraw medical treatment, if that was in the best interests of the patient.

A patient who is not an ‘incompetent patient’ is a ‘competent patient’.

As stated earlier, in the case of a terminally ill patient who is competent, if he refuses treatment, it is binding on the doctors unless the doctors are of the view that the patient's decision is not an informed decision. If a competent patient requires medical treatment be continued, it is not permissible for the doctor to stop or refuse medical treatment.

Such a question also arises in the case of all incompetent patients as well as competent patients whose decision, to refuse medical treatment is not an informed decision.

That is why it is necessary to define who is an 'incompetent person' first and define, in a negative way, who is a 'competent person'.

(2) 'Informed decision'

An 'informed decision' is a decision taken by a competent patient, i.e. an adult who has capacity to take a decision as to his or her medical treatment after understanding the gravity or otherwise of his disease, the availability or otherwise of alternative medicine or technology to cure his disease, the consequences of those forms of treatment and the consequences of remaining untreated. This definition is based on the decisions of the English Courts of Butler Sloss P, Thorpe J and others, to which we have made reference earlier.

(In the case of minors, the doctor's decision as to 'best interests' can override the decision of the guardian.)

(3) 'Best of interests'

Question of 'best interests' have to be decided by a doctor in the case of (a) incompetent patients and (b) in the case of competent patients who are unable to take an informed decision:

It is true, as stated in Lord Goff in Airedale 1993(1) All ER 821 (HL), that on the principle of self-determination, if an adult patient of sound mind refuses, however, unreasonably, to consent to treatment or care by which his life could be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in the best interests of the patient, to do so. To this extent, the principle of sanctity of life must yield to the principle of self-determination. Such refusal by a patient may also be by way of an advance directive.

But, Lord Goff also stated, after referring to In re F (Mental Patient: Sterilisation) 1990(2) AC 1 that, in the case of an unconscious patient, the doctor may treat or continue to treat him if it is in the patient's best interests. The same principle applies when a doctor decides to stop the treatment in the best interests of the patient. He referred to Thomas J in Auckland Area Health Authority vs. AG: 1993(1) NZLR 235 to say that if a doctor decides in the case of a cancer patient, a particular surgery is not in the best interests of the patient, but only palliatives have to be given, it is lawful for him not to go for surgery. When the doctor's treatment of his patient is lawful, the patient's death is regarded as exclusively caused by the disease to which it could be attributed. After quoting from the opinion of Prof. Kennedy and judgment of Thomas J, Lord Goff stated that the question is not whether the

doctor should take a course which would kill a patient, but the question is “whether in the best interests of the patient that his life should be prolonged by the continuance of this form of medical treatment and care”. In the case of an incompetent patient, the straight forward test laid down in In re F (1990)(2) AC1 was whether that was in the best interests of the patient.

Lord Browne-Wilkinson also so stated in Airedale that In re F 1990 (2) AC 1, both Lord Brandon of Oakbrook (p 64) and Lord Goff (at p 75, 77) and made it clear that the right to administer invasive medical care is wholly dependent upon such care being in the interests of the patient. The doctor’s decision whether invasive care is in the best interests of the patient falls to be assessed by reference to the test laid down in Bolam vs. Frien Hospital Management Committee: 1957(1) WLR 582, viz being a decision taken in accordance with a practice accepted, at the time, by a responsible body of medical opinion’. He concluded that ‘if there comes a stage when the responsible doctor comes to the reasonable conclusion (which accords with the view of a responsible body of medical opinion), that further continuance of an intrusive life support system is not in the ‘best interests’ of the patient, he can no longer lawfully continue that life support system for to do so would amount to crime of battery and the tort of trespass to the person.

In Re J (a minor)(Wardship: medical treatment): 1990(3) All ER 930, Lord Donaldson M.R. stated that Court, in deciding to authorize that treatment need not be given, ‘the Court had to perform a balancing exercise in assessing 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 similar judgment, to survive, and taking into account 'the pain and suffering and quality of life' which he would experience if life was to be prolonged and pain and suffering involved in the proposed treatment. Having regard to the invasive and hazardous nature of re-ventilation, the risk of further deterioration of Mr. J if he was subject to the extremely unfavourable progress with or without the treatment, it was in J's best interests that authority for reventilation is withheld.

In re B (A minor)(Wardship: Sterilisation) 1988 (1) AC 199, in the case of sterilization of a mentally retarded 17 year ward, who had only the understanding capacity of a 6 year child, all the courts, upto the House of Lords, were of the view that the child be sterilized in her best interests because pregnancy and childbirth would be totally not in her interests. It was held that sterilization would be in the best interests of the 16 year old child.

In re F (Mental Patient)(Sterilisation) 1990(2) AC 1, (referred to in Airedale), the patient was not a minor but even so, the Court's inherent jurisdiction was invoked (since the *parens patriae* jurisdiction was abolished in UK by statute) and it was held that sterilization was in the best interests of the patient. At common law, a doctor could lawfully operate or give other treatment to adults who were incapable of consenting to his doing so, provided the operation was in the best interests of the patient. The sterilization operation or treatment would be in their best interests 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.

In re T (adult: refusal of medical treatment) 1992(2) All ER 649 (=1992(3) WLR 787) the patient T was a lady, injured in an accident and she was pregnant and required blood transfusion. She was brought up by her mother who belonged to Jehovah's witness school of thought. The patient refused blood transfusion. But, it was held that that the said decision was not her independent view, that she was more influenced by her mother, and hence the decision was not binding on the doctors who felt that it was in the best interests of the patient to be given blood transfusion. In fact, at the emergency stage, the patient herself did not object. It was held that if an adult did not have the capacity, at the time of purported refusal and continued not to have the capacity, or if his or her capacity to take a decision had been over influenced by others, it was the duty of doctors to treat him or her in whatever way they considered, in the exercise of their clinical judgment, to be in his or her best interests.

Re C: (adult: refusal of medical treatment): 1994(1) All ER 819: (competency of patient).

This case was decided by Thorpe J and lays down the C-Test. The patient was 68 years old and was suffering from schizophrenia, developed gangrene and his leg below knee, required to be operated. C refused amputation. The Court considered whether his capacity to take a decision was impaired by schizophrenia and that the presumption of lack of capacity was not displaced and hence his refusal was not binding. In fact, we propose to put these words into the definition of 'incompetent patient'.

Frenchay Health Care NHS Trust vs. S: 1994(2) All ER 403 (CA) was a case where S a healthy adult took a drug overdose which resulted in acute and extreme brain damage. Medical treatment was of no avail. He was fed through a nasogastric tube, through the stomach. At one stage that was removed and re-insertion was likely to result in his death. The hospital moved the Court. The Judge declared that in the patient's interests, the tube should not be re-inserted. The same was affirmed by the Court of Appeal.

Lord Bingham MR held that the Court had to determine whether discontinuance of the tube was in the best interests of the patient. Though the Court had power to review the medical opinion and was not bound to accept it in all cases if circumstances placed before it did not warrant it, the Court would be reluctant to place those treating the patient in a position of having to carry out treatment which they considered to be contrary to the patient's best interests, unless the Court had real doubt about the reliability, bona fide or correctness of the medical opinion in question. The Court followed Airedale.

In re Y (Mental capacity: Bone Marrow Transplant) 1997(2) WLR 556, the question was whether the patient (plaintiff) a 25 year old suffering from cancer, could be given bone marrow transplant from her sister (defendant) who was severely handicapped both mentally and physically. The plaintiff applied to the Court for transplant of bone marrow from her sister.

Connel J observed initially that it was first necessary to consider what was in the best interests of defendant. The fact that the process would

benefit plaintiff was irrelevant, unless such transplant was also in the best interests of the defendant.

But then, if the plaintiff daughter – suffering from cancer - died for want of bone marrow transplant, the death would have an adverse affect on their mother who was caring for both daughters and then the mother's ability to take care of disabled defendant would also be seriously affected. The defendant would benefit, if the plaintiff survived, because of their emotional, psychological and social benefit. The disadvantages to the defendant otherwise was small. After referring to Airedale and Canan vs. Bosze L (1990) 566 NE 2d. 1319 (an American case relating to bone marrow harvesting decided by the Supreme Court of Illinois), the Court permitted the bone-marrow transplant. In the American case too, the donor and the donee were brother and sister. Connel J held that the transplant was good for all three of them, physically and psychologically.

In Re MB (Medical Treatment): 1997 (2) FLR 426 the issue was whether caesarean operation should be performed on a pregnant lady who was refusing blood on account of 'fear of needles'. Butter-Sloss LJ speaking for the Court of Appeal held that where the patient lacked mental capacity and it was in the best interests of the patient, the patient's refusal to treatment was not binding. The patient here was suffering from a needle phobia and was not competent to take a decision and her refusal was not binding. The Court applied the C-Test laid down by Thorpe J in Re C (Refusal of Medical Treatment). 1994(1) All ER 819 to decide about her competency.

Furthermore, since the mother (i.e. the pregnant lady) and the father of the child in the womb wanted that the child be born and the mother was likely to suffer long term damage if the child was born handicapped or dead, it was decided that it was in her best interests that caesarean operation be performed. When the patient did not have the requisite capacity, the doctors were free to decide what was in the patient's best interests.

The Court also held that the best interests were not necessarily medical but they also included the emotional and all other welfare issues.

In Norfolk and Norwich Health Care (NHS) Trust vs. W (1996(2) FLR 613, the lady who was under psychiatric treatment was pregnant but would deny she was pregnant. The Court applied the C-Test. Johnson J held that though she was not suffering from any mental disorder, within the meaning of the statute, she lacked the mental competence to make a decision and the Court permitted forceps delivery or caesarean as it was, according to doctors, in her best interests.

In Re D (Medical Treatment): 1998(2) FLR 10, the defendant, a man of 49 years, suffered from longstanding psychiatric illness and though there was renal failure, haemodialysis was not favoured by the doctors. The Court held that notwithstanding the defendant's inability to consent or to refuse consent to medical treatment, it was lawful that haemodialysis was not given in the best interests of the patient.

Re L: (Medical Treatment: Gillick Competency) 1998(2) FLR 810, the girl was 14 years old in life threatening condition, and she rejected

blood transfusion as she was a Jehovah's witness. The Court did not go by her rejection of blood transfusion as it was only a 'view' of the patient and 'not the constructive formulation of an opinion' on her part which would occur by way of adult experience. She was still a child. She was not given all information to understand the seriousness of her condition. Hence her refusal was not binding and it was in her interests to be given blood transfusion.

In Re A (Male Sterilisation): 2000(1) FLR 55, Butter-Sloss LJ stated that the 'best interests encompass medical, emotional and all other welfare issues'. It was not limited to 'medical' interests'. This principle was applied by Ward LJ in the Siamese Twins Case: Re A (Children) 2000 EW CA 254 where the question was whether the twins be separated by surgery to save one of them while, on such separation, the other would die immediately. In that case, separation was permitted by the Court. Parents' wishes were subordinate to the best interests of the child. (There was discussion in this case as to how far the parents' views should be considered). The broad meaning of 'best interests' as stated above was also reiterated in Simms Vs. An NHS Trust: 2002. EW HC 2734, in which they referred to Re MB: 1997(2) FLN 426.

NHS Trust vs. D: 2003 EWHC 2793, it was held that 'where the issues of capacity and best interests are clear and beyond doubt, an application to the Court is not necessary'. Dame Elizabeth Butler-Sloss referred to the 'best interests', sanctity of life and to Justice Thorpe's dictum in Re A: 2000(1) FLR 549 as to how the Court should prepare a balance sheet of the best interests of a patient, the potential gains and losses etc.

These principles as to how the Court should prepare a balance sheet of the best interests as laid down by Thorpe J in Re A were again applied by Charles J in NHS Trust vs. T : 2004 EW HC 1279. He also quoted Munby J in A vs. A Health Authority 2002 (1) FLR 481 that adults' best interests involve a welfare appraisal in the widest sense of taking into account, where appropriate, a wide range of ethical, social, emotional and welfare consideration.

In Portsmouth NHS Trust vs. Wyatt: 2004 EWHC 2247 Hedley J observed that the child was born after 26 weeks gestation and was weighing 1 lb., and was placed in an incubator. She required oxygen. Kidneys were deteriorating. Parents wanted treatment to be given. The Court gave certain directions to the doctors as regards treatment. In that context, it observed: "infinite variety of the human considerations never cease to surprise and it is that fact that defeats any attempt to be more precise in a definition of best-interests". He, however, referred to Re A 2000(1) FLR 549 that 'best interests' include medical, emotional and other interests.

In GMC vs. Burke 2005 EWCA (CA) 1003 (14) Lord Philips of Worth Matravers stated that autonomy and self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. The Court of Appeal approved Munby J's observations in the Judgment under appeal but took exception to two sentences in regard to which the Court of Appeal stated thus:

“The suggestion that the touch-stone of ‘best interests’ is the intolerability of continued life has, understandably given rise to concern. The test is whether it is in the best interests of the patient to provide or continue ANH must depend upon the particular circumstances.”

It said:

“We do not think it possible to attempt to define what is in the best interests of a patient by a right test, applicable to all circumstances.”

### Summary

From the above case law, it is clear that where a competent patient who is adequately informed, refuses treatment, the doctors are bound by his refusal. But in cases of minors, incompetent persons and PVS patients, the doctor must consider whether giving or continuing or withdrawing treatment is in the best interests of the patient. A balance sheet of advantages and disadvantages has to be drawn as stated by Thorpe J in Re A: 2000(1) FLR 549. The best interests are not confined to medical interests but encompass ethical, social, emotional and welfare considerations. There cannot be any single test of what is in the best interests of an incompetent patient but it must depend upon a variety of considerations depending upon the facts of the case. Where a patient is not competent, it is lawful for doctors to take a decision to give, withhold or withdraw medical treatment if they consider that to be the appropriate action to be taken in the best interests of the patient. We propose to define ‘competent’ and ‘incompetent’ patients, ‘informed decision’ and ‘best interest’ in the proposed Bill.

- 9) Three experts to be consulted in the case incompetent persons (or competent persons who did not make informed decision) to be drawn from panel prepared by proposed statutory authority.

In our view, before the doctor takes a decision in 'best interests' of an incompetent patient or of a competent patient whose decision is not an informed one, expert opinion of three experts must be obtained from experts in the field. Such experts must be drawn by from a panel prepared by a high ranking authority.

While it is, according to us, mandatory for the doctors to consult three specialists who are experts in the treatment of the particular disease from which the terminally ill patient is suffering and while the three experts, according to us, must have atleast 20 years experience, we cannot allow any expert to be consulted at the choice of the above experts. The experts must be selected from a panel which has statutory force. This is intended to avoid malpractices and abuse of the legal provisions. Experts who are under disciplinary action or have been found to be guilty of professional misconduct have to be excluded from he panels. The doctors are allowed to select the experts from the panel prepared by the Director of Medical and Health Services in each State or the Director-General of Medical and Health Services from Union Territories. The nomination of the three experts in a given case need not be by the Director of Medical and Heath Services of the States of the Director General of Medical and Health Services but can be made by the attending doctor.

These three experts to be empanelled as stated above, must be necessarily be medical experts in different subjects or disciplines relating to medicine and surgery with atleast 20 years experience. We, therefore, propose that the above authorities must prepare the panel of experts and that the said authorities may review and modify the panels from time to time. We also propose provision that consultation with three experts is mandatory. If medical treatment is withheld or withdrawn without such consultation, the action will not be lawful under the proposed law.

10 & 11) Court's power to grant a declaration whether the giving or withholding or withdrawing medical treatment is 'lawful' and whether it is binding on a civil or criminal Court in latter proceedings: Whether it is mandatory to seek declaration from Court in every case?

In England and other countries, the doctors or hospitals approach the Court for a declaration that any decision by hem for withholding or withdrawing medical treatment be declared lawful. Again, parents of a patient, whether the patient is minor or not, can also move the Court, if they disagree with the doctor. The parents may want the artificial treatment be still continued or in some cases, discontinued. They can also approach Courts.

In Airedale, Lord Keith of Kinkel observed that it is permissible for doctors or hospitals to seek declarations from Court on the question of lawfulness or otherwise of withdrawal of life-support systems. Initially he observed:

“It is of some comfort to observe that in other common-law jurisdictions, particularly in the United States where there are many cases on the subject, the Courts have, with near unanimity, concluded that it is not unlawful to discontinue medical treatment and care, including artificial feeding, of PVS patients and other in similar conditions.”

He then pointed out that it is permissible to move the Family Court seeking a declaration, to protect the interests of patients, doctors and the families of patients and as a matter of reassurance to the public. This was necessary till a body of case law relating to just ‘medical practice’ containing legal principles is evolved. He said:

“The decision whether or not the continued treatment and care of a PVS patient confers any benefit on him is essentially one for the practitioners in charge of his case. The question is whether any decision that it does not and that the treatment and care should therefore be discontinued as a matter of routine be brought before the Family Division for endorsement or the reverse. The view taken by Sir Stephen Brown and the Court of Appeal was that it should, at least for the time being and until a body of experience and practice has been built up which might obviate the need for application in every case. As Sir Thomas Bingham MR said, this would be in the interests of the protection of patients, the protection of doctors, the reassurance of the patient’s families and reassurance of the public. I

respectfully agree that these considerations render desirable the practice of application.”

In Airedale case, the declarations granted by the Court of Appeal, which were affirmed by the House of Lords, were as follows:

“... that despite the inability of (the defendant) to consent thereto, the plaintiff and the responsible physicians:

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

In Law Hospital NHS Trust v. Lord Advocate (Scotland) 1996 SLT 848, Lord Hope, the Lord President stated that in Airedale, the House of Lords observed that the Courts give a declaration that a doctor’s action would be declared as lawful. The medical profession was entitled to look to the Courts (see Scottish Law Commission Report on Incapable Adults (No.151, para 5.86). Such a declaration could be brought as per the Practice Note of March 1994 by the Official Solicitor (1994 (2) All ER 413).

But Lord Hope went into the question whether such a declaration would be binding on the criminal or civil Courts, when the issue arose before them later. The declaration, of course, was not one asking particular act to be declared as not being a criminal act. “What it seeks is a declaration that the pursuers and the medical practitioner ‘may lawfully discontinue’ the treatment”. In Airedale, in the Family Division, Sir Stephen Browne stated (see p.833 of All ER) that he did not think it appropriate to grant a declaration that the action was not criminal. ‘Lawful’ meant lawful according to civil law. Lord Hope also referred to the observation of Lord Goff of Chievely and Lord Mustill in the House of Lords in Airedale who expressed strong reservations about granting a declaration as to criminality in a civil case. Lord Mustill pointed out that the decision, in any event, would not create an estoppel in the criminal courts which would form a conclusive bar of prosecution. Nevertheless, they did proceed to decide the issue and “it is clear from all the speeches that their Lordships were of the view that the conduct which was proposed would not amount to crime according to the law of England”.

Having said this, Lord Hope doubted if any declaration that might be granted would preclude the criminal Court from going into the question. He held that the Court could not give a declaration that the act was or was not of a criminal nature. The declaration may be useful in another civil case but not in a criminal case. He declared that any declaration which the Court of Sessions, Inner House may make in this matter about the lawfulness of the action would not be binding on the High Court of Justiciary. (In Scotland, the Civil Jurisdiction is with the Court of Sessions, Inner House, while the criminal jurisdiction is with the High Court of

Justiciary). Declaration about lawfulness of the action could be given by the Court of Sessions for purposes of civil liability.

The Practice Directive in 1994 (2) All ER 413: of the official Solicitor spells out the form of declaration:

“The need for the prior sanction of a High Court Judge

1. The termination of artificial feeding and hydration for patients in a persistent vegetative state (PVS) will in virtually all cases require the prior sanction of a High Court Judge: Airedale NHS Trust v. Bland (1993) 1 All ER 821 at 833, (1993) AC 789 at 805 per Sir Stephen Brown P and Frenchay Healthcare NHS Trust v. S (1994) 2 All ER 403.

The Diagnosis

2. The Medical Ethics Committee of the British Medical Association issued guidelines on treatment decisions for patients in persistent vegetative state in July 1993. According to the BMA, current methods of diagnosing PVS cannot be regarded as infallible. Such a diagnosis should not be considered confirmed until the patient has been insentient for at least 12 months. Before then, as soon as the patient’s condition has stabilized, rehabilitative measures such as coma arousal programmes should be instituted (see Airedale NHS Trust v. Bland (1993) 1 All ER 821 at 872, (1993) AC 789 at 871 per Lord Goff). For a discussion of the diagnosis of PVS and of other conditions with which it is sometimes confused, see App 4 (and paras 156-162, 251-258) of the Report of the House of Lords Select Committee on Medical Ethics (HL Paper (1993-94) 21-I).

### Applications to Court

3. Applications to court should be by originating summons issued in the Family Division of the High Court seeking a declaration in the form set out in para 4 below. Subject to specific provisions below, the application should follow the procedure laid down for sterilisation cases by the House of Lords in F v. West Berkshire Health Authority (Mental Health Act Commission intervening) (1989) 2 All ER 545, (1990) 2 AC 1 and in the Official Solicitor's Practice Note of May 1993 [(1993) 3 All ER 222].

4. The originating summons should seek relief in the following form:

‘It is declared that despite the inability of X to give a valid consent, the plaintiffs and/or the responsible medical practitioners: (i) may lawfully discontinue all life-sustaining treatment and medical support measures designed to keep X alive in his existing persistent vegetative state including the termination of ventilation, nutrition and hydration by artificial means; and (ii) may lawfully discontinue and thereafter need not furnish medical treatment to X except for the sole purpose of enabling X to end his life and to die peacefully with the greatest dignity and the least distress.

It is ordered that in the event of a material change in the existing circumstances occurring before the withdrawal of artificial feeding and hydration any party shall have liberty to apply for such further or other declaration or order as may be just.’

5. The case should normally be heard in chambers and the judgment given in open court.

#### The parties

6. The applicants may be either the next of kin or the relevant area health authority/NHS Trust (which in any event ought to be a party). The views of the next of kin are very important and should be made known to the court in every case.

7. The Official Solicitor should be invited to act as guardian ad litem of the patient, who will inevitably be a patient within the meaning of RSC Ord 80.

#### The evidence

8. There should be at least two neurological reports on the patient, one of which will be commissioned by the Official Solicitor. Other medical evidence, such as evidence about rehabilitation or nursing care, may be necessary.

#### The views of the patient

9. The views of the patient may have been previously expressed, either in writing or otherwise. The High Court exercising its inherent jurisdiction may determine the effect of a purported advance directive as to future medical treatment: Re T (adult: refusal of medical treatment) (1992) 4 All ER 649, (1993) Fam 95, Re C (adult: refusal of medical treatment) (1994) 1 All ER 819, (1994) 1 WLR 290. In summary, the patient's previously expressed views, if any, will always be a very important component in the decisions of the doctors and the court.

#### Consultation:

10. Members of the Official Solicitor's legal staff are prepared to discuss PVS cases before proceedings have been issued. Contact with the Official Solicitor may be made by telephoning 071-911-7127 during office hours."

(b) Practice Note: 1996(4) All ER 766:

A further Practice Note was issued by the official Solicitor on withdrawal of treatment in cases of insensate patients and patients in persistent vegetative state – Sanction of High Court required before treatment is terminated – confirmation of diagnosis – Form of Application - Parties to application – Evidence – Views of patients consultation with official Recorder.

We may, however, point out that in Burke (2005), the Court of Appeal clarified that it is not mandatory in every case to obtain Court sanction for withholding or withdrawing treatment. We have already referred to this case.

Frenchay Healthcare NHS Trust v. S: 1994 (2) All ER 403 (CA)

In this case, decided in 1994, Sir Thomas Bingham MR held that where a hospital seeks to discontinue treatment to a PVS, as a general rule, the hospital must apply to the Court and obtain a declaration that it was proper to do so and such an application should be preceded by a full investigation with an opportunity to the Official Solicitor, as the representative of the patient, to explore the situation fully, to obtain

independent medical opinion for himself and to ensure that proper material is placed before the Court. Nevertheless, emergency situations will arise in which an application to the Court is not possible or where, although an application to Court is possible, it will not be possible to present the application in the same leisurely way as in the case where there is no pressure of time.

In 1996, in Re S (Hospital Patient: Courts Jurisdiction) 1996 Jan 1, Sir Thomas Bingham MR said (p.18) that ‘In cases of controversy and cases involving momentous and irrevocable decisions, the Courts have treated as justiciable any genuine question as to what the best interests of a patient require or justify. In making these decisions, the Courts have recognized the desirability of informing those involved whether a proposed course of conduct will render them criminally or civilly liable, they have acknowledged their duty to act as a safeguard against malpractice, abuse and unjustified action; and they have recognized the desirability, in the last resort, of decisions being made by an impartial, independent tribunal’.

In 2003, in NHS Trust v. D: 2003 EWHC 2793, Coleridge J observed that where there is a doubt about the capacity or best interest, an application should be made to the Court. In particular and without limiting the generality of the proposition, the following circumstances would ordinarily warrant making an application (in pregnancy matters):

- ii) where there is a dispute as to capacity, or where there is a realistic prospect that the patient will regain capacity, following a response

to treatment, within the period of her pregnancy or shortly thereafter;

- iii) where there is lack of unanimity amongst the medical professionals as to the best interests of the patient;
- iv) where the procedures under sec. 1 of the Abortion Act, 1967 have not been followed (i.e. where two medical practitioners have not provided a certificate);
- v) where the patient, member of her immediate family or the foetus' father have opposed or expressed views inconsistent with a termination of the pregnancy; or
- vi) where there are other exceptional circumstances (including where the termination may be the patient's last chance to bear a child.

Munby J in his judgment in R (Burke) v. The GMC 2004 EWHC 1879 (Admin) – referred to five situations where where it is proposed to withhold or withdraw ANH, that Court approval must be obtained:

- (i) where there is any doubt or disagreement as to the capacity (competence) of the patient; or
- (ii) where there is lack of unanimity amongst the attending medical professions as to either
  - (a) the patient's condition or prognosis; or
  - (b) the patient's best interests; or
  - (c) the likely outcome of ANH being either withheld or withdrawn; or
  - (d) otherwise as to whether or not ANH should be withheld or withdrawn; or

- (iii) where there is evidence that the patient when competent would have wanted ANH to continue in the relevant circumstances; or
- (iv) where there is evidence that the patient (even if a child or incompetent) resists or disputes the proposed withdrawal of ANH; or
- (v) where persons having a reasonable claim to have their views or evidence taken into account (such as parents or close relatives, partners, close friends, long term carers) assert that withdrawal of ANH is contrary to the parents' wishes or not in the patient's best interest."

But, the Court of Appeal in GMCU vs. Burke: 2005(EWCA) (civ) 1003 (CA) did not agree that in each of these cases the parties must resort to a declaration before a Court of Law. In practice, this is not feasible because if these directives are followed at least 10 cases have to go to Court every day, on an average, in England. The Court of Appeal stated:

"... We do not consider that the Judge is right to postulate that there is a legal duty to obtain Court approval to the withdrawal of ANH in the circumstances that he identifies"

Summarising the judgment, it will be seen that while in Airedale, the House of Lords permitted parties to resort to a declaration only as a matter of "good medical practice", till a body of "experience and practice" was built up. Plainly there would be occasions when it would be advisable for a doctor to seek the Court's approval before withdrawing ANH in other

circumstances, but there was, according to the Court of Appeal, justification in postulating that the doctor was under a legal duty to do so, in all the above five contingencies. Munby J had relied on Coleridge in D v. NHS Trust 2003 EWHC (Fam) 2793. The Court of Appeal distinguished Coleridge J's judgment stating that that was a case of pregnancy of an incompetent adult where, because the legitimacy of such treatment was in doubt, it was 'necessary' to seek authorization from Court. The view of Coleridge J does not transform the requirement to seek Court approval from a matter of 'good practice' into a legal requirement in all the above five situations referred to by Munby J.

Also distinguishing the decision of the European Court in Glass v. UK: 2004 (1) FLR 1019: 2004 Lloyds Rep Med 76, Lord Phillips in the Court of Appeal said:

"The true position is that the Court does not authorize treatment that would otherwise be unlawful. The court makes a declaration as to whether or not proposed treatment, or withdrawal of treatment, will be lawful. Good practice may require medical practitioners to seek such a declaration where the legality of the proposed treatment is in doubt. This is not, however, something that they are required to do as a matter of law. Declaration 6 made by Munby J misstated the law."

In NHS Trust vs. D: 2003 EWHC 2793, it was held that "where the issues of capacity and best interests are clear and beyond doubt, an application to the Court is not necessary."

From the above, the circumstances under which doctors or others can move a civil court for declaration are fairly clear. It is not in every case that it is necessary where there is a conflict of views etc. as stated by Munby J. The Court can be approached as a matter of ‘good medical practice’ to initially build up healthy precedents till a body of ‘experience and practice’ is built up.

It is necessary to provide in the proposed Bill that patients, parents, hospitals or doctors can approach the Courts either on the question of withholding or withdrawing artificial medical treatment or starting or for continuance of the said treatment.

13) Confidentiality:

For medical patients, privacy rights are quite important and, therefore, it is essential, in the matter of serious cases involving life and death related issues which come before the Courts seeking declaratory remedies, that utmost secrecy has to be maintained with regard to the names of the patients, their parents, the hospitals, opinions of experts or doctors, in the judgments.

Even where the parties do not move the Courts, the media may publish the legal principles decided or directions given but cannot disclose facts which will identify the patients, parents, relatives, doctors, experts, or hospitals.

Lord Donaldson in Re C (a Minor) (Wardship: medical treatment): 1989 (2) All ER 782 pointed out as follows:

“What is required in such cases is that the Judge should give judgment in open Court, taking all appropriate measures to preserve the personal privacy of those concerned..... Thus, in this judgment, I have quoted extensively from the Professor’s advice without, I hope, giving any clue as to his identity or that of C, her parents or the authority involved”

In a subsequent order in the same case reported in Re C (a minor) (Wardship: medical treatment) No.2 (A): 1989 (2) All ER 791, the two newspapers, Daily Mail and Mail Sunday filed applications before the Court of Appeal to review the above judgment. They wanted that the confidentiality directive in the above judgment regarding the identity of patients, parents, doctors, hospital and medical advice be reconsidered and the media be permitted to publish the details.

After an elaborate reconsideration, the Court of Appeal stated that privacy of the patient was important and undue publicity about the medical treatment of the ward could affect the quality of care given to the patient, and that the public interest in ensuring proper quality of care required the Court, in the best interests of the patient, to issue an injunction prohibiting the identification of the patient, his or her parents, the medical information etc., notwithstanding that the patient is not capable of noticing such identification or publicity. Further, such an injunction would reinforce the duty of confidentiality owed by those caring for her. (Doctors are supposed

to maintain privacy so far as their patient's name, address, parents' name, doctor's name, medical treatment etc. are concerned). The injunction against identifying the parents is also justified in order to protect the wardship jurisdiction since parents might refuse to make a child a ward of Court (or an incompetent patient) if they thought that they might be identified and singled out for media attention.

The Court in the above case, prohibited external publication of the names, but it stated that the doctors and hospital or the local authority (which is protecting the ward) must know the real name of the patient so that the Court's orders could be implemented.

In Law Hospital NHS Trust v. Lord Advocate (Scotland) (1996) SLT 848, the Lord President, Lord Hope stated that cases of such patients be heard in chambers without intimation on the notice board, unless public interest requires.

It is proposed to have a provision in the Bill (a) for keeping the identity of the patients, parents, doctors, experts, witnesses, hospital as confidential, in the High Court where the petition will be filed by the patient, parents or doctors and that they will be designated by English alphabets. It is proposed that the High Court should, at the stage of filing of the case, pass an order giving the alphabetical designations and that while referring to the Court orders, no person, law report, or media shall publish the names of the above persons or hospital. Breach of the order as to confidentiality may be punished under the Contempt of Courts Act. However, it is necessary that, in the orders to be communicated to the above parties, doctors or hospital,

the actual name will have to be given because it is necessary that the identity of the patient and others be known to the above persons, doctors and the hospital, so that the order can be implemented. However, such communications should be put in a sealed cover.

It is also proposed (b) that even in cases where the matters do not go to Court none including the media should publish facts which will lead to identification of the patients, parents, relatives, doctors, hospitals, experts etc.

#### 14) Position under Indian Penal Code & Law of Torts

In the light of the discussion in Chapters I to VI and this Chapter, we now come to the crucial issues of criminal law and law of torts in regard to which, it is necessary to remove certain apprehensions in the minds of patients, doctors, hospitals and others.

We shall first deal with (A) the Criminal Law and then with (B) the Law of Torts.

##### (A) Criminal Law:

We have, in a way dealt with the questions briefly in Chapter II where we referred to Gian Kaur v. State of Punjab, 1996 (6) SCC 648. We have dealt with 'Euthanasia' and its various forms and 'Assisted Suicide' in various countries in this Chapter. We have again referred in the same

Chapter VI to the scope and effect of a declaration by the Court that withdrawal of life support systems, in certain circumstances is lawful.

We shall first refer to the specific provisions of the Indian Penal Code, 1860 which are relevant in this connection.

Inasmuch as the Supreme Court in Gian Kaur specifically stated that Euthanasia and Assisted Suicide are not lawful, it is obvious that so far as Euthanasia and Assisted Suicide are concerned, they will fall within one or other of the penal provisions and continue to be unlawful and we do not propose going to Euthanasia and Assisted Suicide.

We shall confine ourselves to discussing the cases of stoppage of life sustaining treatment to patients.

As seen in the foregoing chapters, the issue arises with regard to different categories of patients as stated below:

- (a) Competent patients: position of patients and doctors: No offence committed under Indian Penal Code, 1860:

The discussion under (a) must necessarily start with the principle repeatedly laid down in several countries that under common law that a patient has to give his consent (informed consent) to medical treatment, including invasive treatment. Likewise, if a patient refuses medical treatment and wants nature to take its own course, his right to refuse such

treatment is accepted by the common law and is binding on the doctors, provided the decision is an informed decision. We shall elaborate..

If a competent patient states that the medical treatment being given to him or her is to be continued, the doctors are bound by the patient's decision and cannot discontinue the treatment. At the same time, it is well settled that it is not for the patient to require a doctor to give him a particular medical treatment where the doctor is of the view that that is not the appropriate treatment.

When the patient is competent and wants withholding or withdrawal of treatment, that decision is also binding on the doctors provided the doctor is satisfied that the patient is competent and that this decision of the patient is an informed one, i.e. that the patient has been informed about the granting or otherwise of the ailment, and the medicine or treatment available, patient is able to retain the information, weigh the pros and cons, and take an informed decision. But where the doctor is satisfied that the competent patient's decision is not an informed decision, or that it is based on wrong assumption or prejudices, phobia or hallucinations, then the doctor can ignore the patient's decision and decide what is in the best interests of the patient according to the view of a body of medical experts.

The common law accepts that once the patient instructs the doctor that he is not willing for treatment, that decision is binding on the doctor and if a doctor attempts to treat or treats a patient against his will, it will amount to battery and in some cases, if death ensues, he may also be liable for the offence of murder. While it is true that doctors have a duty by

virtue of their profession to treat a patient and omission to treat may, in certain circumstances, be an offence still, where the doctor obeys the competent patient's instructions, he is absolved of his professional duty and his omission will not be an offence.

In case the patient who refuses medical treatment and the doctor's precluded from administering medical treatment, the doctor must however be satisfied that the patient has taken an informed decision or the decision is voluntary. We have seen cases where a patient refuses blood transfusion on ground that such blood is evil, or because of needle phobia. If such is the case, the patient's refusal is not binding on the doctor and if he thinks that the best interests of the patient requires treatment, he is not committing any offence even if the treatment is contrary to the patient's desire. There may also be cases like Jehovah's witnesses who abhor blood transfusion but if a patient has no such faith but his parent belongs to that faith and has forced his or her views on the patient, then the refusal of the patient is not binding.

With reference to competent patients under category (a), let us see if the patient or the doctor is guilty when these principles are correctly applied.

### Criminal Law

#### (A) Section 309: attempt to commit suicide (by patient):

So far as the patient is concerned, when he refuses treatment, is he guilty of 'attempt to commit suicide'?

The definition of ‘attempt to commit suicide, is contained in sec. 309 which reads as follows:

“Sec. 309: Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine or with both”

‘Suicide’ has not been separately defined but generally means ‘a deliberate termination of one’s own physical existence’.

But, that is different from a patient allowing nature to take its own course. When a person is suffering from disease, he may take medicine to cure himself. There are different systems of medicine and he may feel that none is good enough. Further in the last four or five decades, medical science and technology have progressed so much but medical facilities available in other countries may not be available in India, or those available in India may not be available at the place where the patient is living and his decision not to take medicine may be based on those facts. Apart from these considerations, a patient may decide for himself that he will allow the disease or illness to continue and be not bothered by taking medicines or invasive procedures. An attitude where a patient prefers nature to take its course has been held in almost all leading countries governed by common law, as pointed out in the preceding chapters, as not amounting to an act of deliberate termination of one’s own physical existence. It is not like an act of deliberate or intentional hanging or shooting one’s self to death or attempting to drown in a well or a river or in the sea. In view of the settled

law on this aspect, allowing nature to take its course and not taking medical treatment is not an attempt to commit suicide. Hence there is no offence under sec. 309. In fact, in Airedale the House of Lords clearly held it is not suicide.

(B) Section 306: abetment to commit suicide: (abetment by doctor in relation to competent patients):

So far as the doctor is concerned, let us consider if sec. 306 which deals with 'abetment to commit suicide' applies. Sec. 306 deals with this offence. It reads:

“Sec. 306: If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall be liable to fine”

Once the competent patient decides not to take medicine and allows nature to take its course, the doctor has to obey the instructions. Administering medicine contrary to the wishes of a patient is battery and is an offence. The omission to give medicine is based on the patient's direction and hence the doctor's inaction is not an offence. In fact, when there is no attempt at suicide or suicide under sec 309, there can be no abetment of suicide under sec 306.

© Even under sec 107 of the Indian Penal Code (which we have extracted in Chapter II) which generally deals with 'abetment', the position

is the same. Under that section ‘abetment’ may be by a positive act or even by omission. If a doctor omits to give medical treatment at the instructions of a competent patient, he is not guilty of ‘abetment’ under sec 107, because under sec 107 the omission must be “illegal”. If under common law, the doctor is bound by the patient’s instruction for stoppage of treatment, it is binding on him and his omission is ‘legal’. As there is no requirement under the law that he can disobey the instruction, he is not guilty of abetting. In fact, if he disobeys and continues the medical treatment it will amount to battery or assault.

We have seen in Airedale (UK) and Cruzan (USA) the question of the doctor’s omission has been considered elaborately and it has been held that where there is no duty under common law to give or continue the medical treatment, the omission of the doctor does not amount to an offence. Hence, the doctor is not guilty of ‘abetment of suicide’ under sec. 306 IPC, even if we read sec. 306 along with sec. 107 which deals generally with ‘abetment’.

(b) Doctors action in respect of incompetent patients and competent patients who have not taken informed decision: If it amounts to an offence, it clearly falls under exception in Indian Penal Code, 1860:

(A) Section 299: culpable homicide:

Even if the cases under (a), where the adult patient who is competent refuses treatment, on the basis of informed decision, does not involve the offences of ‘attempt to suicide’ (sec. 309) and ‘abetment of suicide’ (sec. 306), it is still necessary to consider whether the action of the doctor in

refusing to provide medical treatment, though with consent of the competent patient, amounts to ‘culpable homicide’ not amounting to murder. The question of ‘culpable homicide’ also arises where in the cases of incompetent patients and competent patients who have not taken informed decision, and the doctor takes a decision to withhold or withdraw treatment in the best interests of the patient.

Sec. 299: of the Indian Penal Code, 1860 reads as follows:

“Sec. 299: culpable homicide:

Whoever causes death by doing an act with the intention of causing death, or with the intention of causing such bodily injury as is likely to cause death, or with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide.

Explanation 1: A person who causes bodily injury to another who is labouring under a disorder, disease or bodily infirmity, and thereby accelerates the death of that other, shall be deemed to have caused the death.

Explanation 2: Where death is caused by bodily injury, the person who causes such bodily injury shall be deemed to have caused the death, although by resorting to proper remedies and skilful treatment the death might have been prevented.

Explanation 3: The causing of the death of child in the mother’s womb is not homicide. But it may amount to culpable homicide to cause the death of a living child, if any part of that child has been brought forth, though the child may not have breathed or been completely born.”

Under sec. 299, whoever causes death by doing an act –

- i) with the intention of causing death, or
- ii) with the intention of causing such bodily injury as is likely to cause death, or
- iii) with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide.

Therefore, if death is caused with the knowledge that he, the doctor, is likely. by such act to cause death, then, the act amounts to culpable homicide not amounting to murder and is punishable under sec. 304 which may extend upto ten years imprisonment, fine or both. It will not be an offence if the act comes within any exceptions provided in the Penal Code.

Elaborating the above, we may state again that under the main part of sec 299, the doctor is not guilty because he had no intention to cause death or bodily injury which is likely to cause death. But where he knows that withdrawal of life support will cause death, is he guilty under sec 299? Now under this third part of sec 299, he will be guilty only if the knowledge above mentioned was that the act of withdrawal would cause death. This third part gets attracted to the act of the doctor and he will be guilty of culpable homicide not amounting to murder, punishable under Part II of sec 304. We shall consider separately whether the exceptions in ss 76, 79, 81 and 88 of the Penal Code apply to protect the doctor. We shall consider the applicability of sec 299 in the case of (i) competent patients, informed decision, (ii) competent patients, no informed decision and (iii) incompetent patients, separately

(i) Competent patient: Informed decision:

Where a patient who is competent refuses medical treatment and the doctor obeys and withholds or withdraws treatment, then does the doctor commit an offence under sec 299?

The first and second parts of the section 299 do not apply because there is no 'intention' either to cause death or bodily injury likely to cause death. But, the act may fall under the third part because the doctor has 'knowledge' that the act of withdrawal is likely to cause death. Therefore, there can be an offence under sec 299. (As to exceptions, we shall refer to it lower down).

(ii) Competent patient: No informed decision:

When a patient is competent but the decision is not an informed one, the doctor has to take a decision in the best interests of the patient.

Here too, he may not have the intention referred to in the first and second parts of sec 299 but he has the 'knowledge' referred to the third part of sec 299. Therefore, he may be guilty of an offence under sec 299 (As to exceptions, we shall refer to it lower down).

(iii) Incompetent patient:

Here the doctor is satisfied that the patient is incompetent and he takes a decision to discontinue treatment, in the best interests of the patient.

Here too, there is no intention as referred to in the first and second parts of sec 299, but he has the ‘knowledge’ referred to in third part of sec 299. Here he may be liable for an offence under sec 299. (As to exception, we shall refer to them lower down.)

Exceptions:

Section 76 (Exception)

(B) Section 76 reads as follows:

“Section 76: Act done by a person bound by mistake of fact believing him bound by law : Nothing is an offence which is done by a person who is, cited by reason of a mistake of fact and not by reason of a mistake of law in good faith believe himself to be, bound by law to do it.”

We are referring to this section because the “Guidelines for limiting life-prolonging interventions and providing palliative care towards the end of life in Indian Intensive Care Units” (Extensive study of the Position Statement of the Ethics Committee of India Society of Critical Care Medicine) contains an appendix (Legal Provisions in Indian Law for Limiting Life Support), in which sec 76 has been discussed. (Appendix was prepared by Sri S. Balakrishnan, Senior Advocate, Supreme Court and Sri R.K. Mani, Consultant Pulmunologist and Intensivist.

In our view, sec 76 is attracted to the case of doctors taking action to withhold or withdraw treatment in the case of refusal to medical treatment by a competent patient. Such refusal being binding on the doctor (provided, of course, the doctor is satisfied that the patient is competent and the patient's decision is an informed one). In such cases sec 76 brings the doctor's action under the exception.

(C) Section 79: (exception)

“Section 79: Nothing is an offence which is done by any person who is justified by law or by reason of mistake of fact and not by reason of mistake of law in good faith, believes himself to be justified by law in doing it.”

The act of withholding or withdrawing medical treatment in all the cases (i), (ii) and (iii) above will fall under the exception if the said act is “justified by law”.

This section applies to the doctor's action in the case of both competent and incompetent patients.

In our view, in the light of the judgment in Gian Kaur of the Supreme Court, Airedale of the House of Lords and Cruzan of the American Supreme Court and judgments in Canada, Australia and New Zealand, the common law confers a duty on the doctor to withhold or withdraw treatment if so instructed by a competent patient. In the case of a competent patient who has not taken an informed decision and in the case of an incompetent

patient, the doctors are justified, under the circumstances to withdraw treatment if it is in the best interests of the patient. Hence the action is ‘justified by law’ and in all cases (i), (ii) and (iii), he is protected by sec 79 first part. If he is mistaken in his decision to withdraw life support, and the decision is in good faith, he is protected by second part of sec 79, both in the case of competent and incompetent patients.

In respect of sec 79, Raj Kapoor vs. Laxman: AIR 1980 SC 605 decided the meaning of the words “justified by law”. It was observed:

“The position that emerges is this. Jurisprudentially viewed, an act may be an offence, definitionally speaking: but a forbidden act may not spell inevitable guilt if the law itself declares that in certain circumstances, it is not to be regarded as an offence. The Chapter on General Exception operates in this provision. Section 79 makes an offence a non-offence. When? Only when the offending act is actually justified by law or is bona fide believed by mistake of fact to be so justified.

It is also stated, after referring to dictionary that “Lexically the sense is clear. An act is justified by law if it is warranted, validated and made blameless by law.”

In the light of the Judgment in Gian Kaur, Airedale, Cruzan & other cases referred to in the previous Chapter read with Raj Kapoor, the withholding or withdrawal of life support system in the case of competent patient on account of the patient’s refusal to treatment, and in the case of

incompetent patients (and ‘competent patients’ whose decision is not informed) if the action was in the patient’s best interests,- then the act of omission of the doctor is lawful, i.e. ‘justified by law’. Hence the doctors are protected.

(D) Section 81: (exception)

“Section 81: Act likely to cause harm, but done without criminal intent, and to prevent other harm:

Nothing is an offence merely by reason of its being done with knowledge that it is likely to cause harm, if it be done without any criminal intention to cause harm, and in good faith for the purposes preventing or avoiding other harm to person or property.

Explanation: It is a question of fact in such a case whether the harm to be prevented or avoided was of such a nature and so imminent as to justify or excuse the risk of doing the act with the knowledge that it was likely to cause harm.”

This section may be applicable both in cases of competent or incompetent patients but involves proof of several questions of fact, even if there is no criminal intent. In our view, ss 76 and 79 give far greater protection than sec 81. Further, this section covers cases of ‘necessity’ and only speaks of ‘harm to person or property’, whereas here we are dealing with death.

(E) Section 88: (Exception)

Section 88: Action not intended to cause death, done by consent in good faith for person's benefit

“Nothing which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent whether express or implied; to suffer that harm or to take the risk of that harm.”

This section applies to competent patients who give consent but the consent is for acts which will cover 'benefit'. This section also requires several facts to be proved and question is of 'benefit'. We must go to the extent of saying that death relieves pain or suffering and is beneficial.

In our view, ss 76, 79 are more appropriate than sec 88 and there is no offence under sec 299 read with sec 304 of the Penal Code.

Section 304A: (causing death by negligence): (position of doctor).

We next come to sec. 304A which deals with criminal negligence vis-à-vis the position of doctors, the Supreme Court in Jacob Mathew State of Punjab 2005 (6) SCC 1.

Sec. 304A speaks of 'causing death by negligence'. It says:

“Sec. 304A: Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine or with both.”

The Supreme Court in Jacob Mathew’s case referred to ss. 88, 92, 93 and 304A of the Penal Code and stated that for purposes of criminal law, so far as doctors are concerned, sec. 304A requires ‘gross negligence’ to be proved. The Court pointed out that it must be established that no medical professional in his ordinary senses and prudences would have done or failed to do the thing which was attributed to the accused-doctor.

In our view, where a medical practitioner is under a duty at common law to obey the refusal of a patient who is an adult and who is competent, to take medical treatment, he cannot be accused of gross negligence resulting in the death of person within the above parameters. Likewise in the case of a competent patient, whose decision is not an informed one and in the case of an incompetent patient, if the doctor decides to withhold or withdraw treatment in the best interests of the patient and that is based upon the expert opinion of a body of experts, then the action of withholding or withdrawal cannot be said to be a grossly negligent act. Hence sec 304A is not attracted. The doctor is merely going by the wish of the patient to allow nature to take its course. Therefore, sec. 304A is not applicable.

Summary:

Thus, the provisions of sec 299 even if attracted to the cases of the doctor, ss 76 and 79 protect that action. Sec 304A is not applicable.

### Civil Liability – Torts:

So far as civil liability of the doctors under the law of torts is concerned, the position as per the discussion in the previous chapters, is as follows:

- (a) Where the competent patient who is afflicted by serious disease, refuses treatment after being duly informed about all aspects of the disease and treatment, the doctor is bound to obey the same and withhold or withdraw treatment. There is no duty to start or continue treatment, if a properly informed patient refuses to receive medical treatment. If death ensues on account of the doctor obeying the patient's refusal, then there is no cause of action to sue the doctor for negligence, seeking damages.
- (b) Where the patient is incompetent, either being a minor or person of unsound mind or is, on account of the pain and suffering or on account of his being in a persistent vegetative state, unable to take decisions as to whether he would or would not have medical treatment, the doctor has to take a decision in the best interests of the patient based upon an informed body of medical opinion of experts. In that case, as he is acting in good faith, his action in withholding or withdrawing medical treatment is protected and he is not liable in tort for damages.

- (c) In the case of competent patient who has not taken an informed decision, the doctor's action taken in the best interests of the patient is lawful and what we said under (b) equally applies here.

The civil liability of doctors in torts is discussed in several decisions of the Supreme Court but suffice it to refer to the recent decision of the Supreme Court in Jacob Mathew: 2005 (6) SCC page 1, State of Punjab vs. Shiv Ram: 2005(7) SCC 1 and State of Haryana vs. Raj Rani: 2005(7) SCC 22. The Supreme Court accepted the principles laid down in Bolam: 1957 (1) WLR 582 and the law is stated in Halsbury's Laws of England (4<sup>th</sup> Ed, Vol 30, para 35) as follows) so far as civil liability under the law of torts is concerned:

“The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence – judged in the light of the particular circumstances of each case,- is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed a different treatment or operated in a different way; nor is he guilty of negligence if he has acted accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, even though a body of adverse opinion also existed among medical men.

Deviation from normal practice is not necessarily evidence of negligence. To establish liability on that basis, it must be shown (1) that there is a usual and normal practice; (2) that the defendant has

not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken, had he been acting with ordinary care”

The Supreme Court in Jacob Mathew also stated something as to civil liability which is particularly relevant in the present context. It stated (p. 21 SCC):

“The usual practice prevalent nowadays is to obtain the consent of the patient or of the person-in-charge of the patient if the patient is not in a position to give consent before adopting a procedure. So long as it can be found that the procedure which was in fact adopted was one which was acceptable to medical science as on that date, the medical practitioner cannot be held negligent merely because he chose to follow one procedure and not another and the result was failure”

Summary:

In the light of the above principles, the decision of a doctor to withhold or withdraw life saving treatment based upon the view of an expert body of medical men in the particular field is therefore not actionable in tort.

Proposal in draft Bill:

We, however, propose a section, by way of abundant caution, that in case of a doctor withholds or withdraws medical treatment, i.e. artificial nutrition or hydration, in respect of terminally ill patients, then the act or

omission is lawful. If it is 'lawful', it is 'justified by law' for purposes of section 79:-

- (a) in the case of competent patient, the patient has refused treatment unless the doctor is satisfied that the patient is not competent or that the patient's decision is not an informed decision.
- (b) In the case of an incompetent patient, the doctor has acted in the best interests of the patient and has consulted at least three medical practitioners.
- (c) In the case of a competent patient, the patient has not taken an informed decision and the doctor has acted in his best interests, the position is akin to (b).

In fact, in the case of a competent patient whose decision is an informed one, it is the duty of the doctor to go by the patient's refusal as it is binding on him.

- 14) a) Guidelines by Medical Council of India : Provisions in proposed Bill is necessary  
Medical Council may consult expert bodies including Indian Society for Critical Care Medicine:

Medical Council of India has not issued any separate guidelines in relation to the subject under study, except the following:-

The Medical Council of India in exercise of the powers conferred under section 20A read with section 33(m) of the Indian Medical Council Act, 1956, with the previous approval of the Central Government, has made Regulation relating to the Professional conduct, Etiquette and Ethics for medical practitioners, namely, “The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.” Chapter I deals with Code of Medical Ethics.

Regulation 1.1 deals with character of the Physician. According to it, a physician should uphold the dignity and honour of his profession. The prime object of the medical profession is to render service to humanity. Regulation 1.2 deals with the need to maintain good medical practice. It states that the principle of the medical professional is to render service to humanity with full respect for the dignity of profession and man. Physicians should merit the confidence of patients entrusted to take their care, rendering to each a full measure of service and devotion. Chapter 6 deals with unethical acts. It says that “a physician shall not aid or abet or commit any of the following acts which shall be construed as unethical”. Regulation 6.7 declares ‘euthanasia’ as an unethical act. It reads as follows:

“6.7 Euthanasia: Practicing euthanasia shall constitute unethical conduct. However on specific occasions, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support-system. Such team shall consist of the doctors in charge of the patient, Chief Medical Officer/Medical Officer In-

charge of the hospital and a doctor nominated by the in-charge of the hospital staff in accordance with the provisions of the Transplantation of Human Organ Act, 1994.”

As per Regulation 7.1, a physician, if he or she commits any violation of these regulations, shall be guilty of professional misconduct and liable for disciplinary action.

Ethics Committee of the Indian Society of Critical Care Medicines has made ‘Guidelines for limiting life prolonging interventions and providing palliative care towards the end of life in Indian Intensive care Units. These guidelines are eight in number and read as follows:

- i. The physician has a duty to disclose to the capable patient or family, the patient’s poor prognosis with honesty and clarity when further aggressive support appears non-beneficial. The physician should initiate discussions on the treatment options available including the option of no specific treatment.
- ii. When the fully informed capable patient or family desires to consider palliative care, the physician should offer the available modalities of limiting life-prolonging interventions.
- iii. The physician must discuss the implications of forgoing aggressive interventions through formal conferences with the capable patient or family, and work towards a shared decision-making process. Thus, he accepts

patient's autonomy in making an informed choice of therapy, while fulfilling his/her obligation to provide beneficent care.

- iv. Pending consensus decisions or in the event of conflicts between the physician's recommendations and the family's wishes, all existing supportive interventions should continue. The physician however, is not morally obliged to institute new therapies against his/her better clinical judgment.
- v. The discussions leading up to the decision to withhold life-sustaining therapies should be clearly documented in the case records, to ensure transparency and to avoid future misunderstandings. Such documentation should mention the persons who participated in the decision-making process and the treatments withheld or withdrawn.
- vi. The overall responsibility for the decision rests with the attending physician/intensivist of the patient, who must ensure that all members of the caregiver team including the medical and nursing staff agree with and follow the same approach to the care of the patient.
- vii. If the capable patient or family consistently desires that life support be withdrawn, in situations in which the physician considers aggressive treatment non-beneficial, the treating team is ethically bound to consider withdrawal within the limits of existing laws.

- viii. In the event of withdrawal or withholding of support, it is the physician's obligation to provide compassionate and effective palliative care to the patient as well as attend to the emotional needs of the family.

Proposal:

We propose a section in the Act requiring medical practitioners to be guided by the Guidelines of the Medical Council of India for purposes of the Act, and the Council may revise and modify the same from time to time. The Guidelines must relate to the principles to be borne in mind by medical practitioners as to the circumstances under which a medical practitioner may withhold or withdraw medical treatment, including artificial nutrition and hydration, in case of patients who are terminally ill. The Guidelines must deal with competent and incompetent patients, informed decisions and best interests and other aspects referred to in this Report and in the draft bill annexed to this Report.

In the Medical Council (Professional Conduct, Etiquette and Ethics) Regulation 2002, a study of Reg. 6.7 gives an impression that a certain procedure indicated there is to be followed. The heading 'Euthanasia' is referable only to the first sentence and does not apply to the rest of Reg. 6.7. No distinction is made between competent and incompetent patients in Reg. 6.7. In fact, it will be useful if a separate set of regulations dealing with 'withholding and withdrawal of life support systems' (which is different from Euthanasia) is prepared and published.

We hope the medical Council of India will make a thorough study of this Report of the Law Commission, the statutes and case law referred to in this Report and in particular in this chapter, before preparing any such guidelines. The guidelines must be consistent with the provisions of the proposed Act.

While evolving guidelines, the Medical Council of India may consult various other expert bodies like the Society for Critical Care Medicine, India Chapter.

We propose a provision in the Bill requiring the Medical Council of India to issue guidelines and publish the same in the Gazette of India.

#### Draft Medical Treatment (Protection of Patients, Doctors) Bill

We propose a draft of the Bill in the light of the preceding chapters on the subject of ‘Medical Treatment (Protection of Patients, Doctors). While preparing this draft, we have kept in mind the Parliamentary legislation on a connected subject, namely, the ‘Medical Termination of Pregnancy Act, 1971’.

## Chapter VIII

### Summary of Recommendations

In the previous chapters, we have considered various important issues on the subject of withholding or withdrawing medical treatment (including artificial nutrition and hydration) from terminally ill-patients. In Chapter VII, we have considered what is suitable for our country. Various aspects arise for consideration, namely, as to who are competent and incompetent patients, as to what is meant by ‘informed decision’, what is meant by ‘best interests’ of a patient, whether patients, their relations or doctors or hospitals can move a Court of law seeking a declaration that an act or omission or a proposed act or omission of a doctor is lawful, if so, whether such decisions will be binding on the parties and doctors, in future civil and criminal proceedings etc. Questions have arisen whether a patient who refuses treatment is guilty of attempt to commit suicide or whether the doctors are guilty of abetment of suicide or culpable homicide not amounting to murder etc. On these issues, we have given our views in Chapter VII on a consideration of law and vast comparative literature.

In this chapter, we propose to give a summary of our recommendations and the corresponding sections of the proposed Bill which deal with each of the recommendations. (The draft of the Bill is annexed to this Report). We shall now refer to our recommendations.

1) There is need to have a law to protect patients who are terminally ill, when they take decisions to refuse medical treatment, including artificial

nutrition and hydration, so that they may not be considered guilty of the offence of ‘attempt to commit suicide’ under sec. 309 of the Indian Penal Code, 1860.

It is also necessary to protect doctors (and those who act under their directions) who obey the competent patient’s informed decision or who, in the case of (i) incompetent patients or (ii) competent patients whose decisions are not informed decisions, and decide that in the best interests of such patients, the medical treatment needs to be withheld or withdrawn as it is not likely to serve any purpose. Such actions of doctors must be declared by statute to be ‘lawful’ in order to protect doctors and those who act under their directions if they are hauled up for the offence of ‘abetment of suicide’ under sections 305, 306 of the Indian Penal Code, 1860, or for the offence of culpable homicide not amounting to murder under sec. 299 read with sec. 304 of the Penal Code, 1860 or in actions under civil law.

2) Parliament is competent to make such a law under Entry 26 of List III of the Seventh Schedule of the Constitution of India in regard to patients and medical practitioners. The proposed law, in our view, should be called ‘The Medical Treatment of Terminally Ill Patients (Protection of Patients, Medical Practitioners) Act.

3) So far as ‘definitions’ of certain important words are concerned, we propose a number of definitions which will reflect the meaning of various important words.

(a) There must be a definition of ‘patient’ as a patient who is suffering from ‘terminal illness’, because we are concerned only with such patients in this Report. (See sec. 2(a))

(b) There must be a definition of a ‘competent patient’ and also of an ‘incompetent patient’. In this context, we felt that it would be advantageous to give a detailed definition of an ‘incompetent patient’ (see sec. 2(d)) and define a ‘competent patient’ (see sec. 2(c)) as one who is not an ‘incompetent patient’.

So far as the definition of an ‘incompetent patient’ (sec. 2(d)) is concerned, we are of the view that the definition must reflect the various aspects covered by C-Test of Justice Thorpe. The definition of ‘competent’ and ‘incompetent patients’ must, in our view, be as follows:

- (a) “‘competent patient’ means a patient who is not an incompetent patient.”
- (b) “‘incompetent patient’ means a patient who is a minor or person of unsound mind or a patient who is unable to
- (i) understand the information relevant to an informed decision about his or her medical treatment;
  - (ii) retain that information;
  - (iii) use or weigh that information as part of the process of making his or her informed decision;
  - (iv) make an informed decision because of impairment of or a disturbance in the functioning of his or her mind or brain; or
  - (v) communicate his or her informed decision (whether by speech, sign, language or any other mode) as to medical treatment.”

(c) There must be a definition of ‘terminal illness’ because the question of withholding or withdrawal of medical treatment relates only to such patients (see sec. 2(m)). In our view, the definition must be as follows:

“‘terminal illness’ means

- (i) such illness, injury or degeneration of physical or mental condition which is causing extreme pain and suffering to the patient and which, according to reasonable medical opinion, will inevitably cause the untimely death of the patient concerned, or
- (ii) which has caused a persistent and irreversible vegetative condition under which no meaningful existence of life is possible for the patient.”

(d) The definition of ‘medical treatment’ (see sec. 2(i)) as given to terminally ill patients includes artificial nutrition and hydration. In our view, the definition must be as follows:

“‘medical treatment’ means treatment intended to sustain, restore or replace vital functions which, when applied to a patient suffering from terminal illness, would serve only to prolong the process of dying and includes

- (i) life-sustaining treatment by way of surgical operation or the administration of medicine or the carrying out of any other medical procedure and
- (ii) use of mechanical or artificial means such as ventilation, artificial nutrition and hydration and cardiopulmonary resuscitation.”

(e) There must be a definition of an ‘informed decision’ (see sec. 2(e)) which a competent patient is supposed to take about his medical treatment. It must reflect the various aspects referred to by us in the earlier chapters.

In our view, ‘informed decision’ must be defined as follows:

“‘informed decision’ means the decision as to starting or continuance or withholding or withdrawing medical treatment taken by a patient who is competent and who is, or has been informed about

- (i) the nature of his or her illness,
- (ii) any alternative form of treatment that may be available,
- (iii) the consequences of those forms of treatment, and
- (iv) the consequences of remaining untreated.”

(f) There must be a definition of ‘best interests’ of the patient (see sec. 2 (b)) i.e. in regard to (i) an incompetent patient, in regard to whom the doctor takes a medical decision in the patient’s best interests, (ii) competent patients whose decision is not an informed one. The definition should reflect the meaning given by Justice Thorpe, Dame Butler-Sloss and others in decided cases referred to by us where it is said that the best interests are not confined to medical interests but include the ethical, social, moral, emotional and other welfare considerations of the patient.

In our view, the definition of ‘best interests’ must be as follows:

“‘best interests’ include the best interests of a patient

- (i) who is an incompetent patient, or

- (ii) who is a competent patient but who has not taken an informed decision, and  
are not limited to medical interests of the patient but include ethical, social, moral, emotional and other welfare considerations.”
- (g) ‘Palliative care’ (see sec. 2(k)) is permissible to be given by doctors for securing relief from pain and suffering even where the doctor obeys the informed decision of a competent patient to withhold or withdraw the medical treatment. This definition must also be applicable to ‘incompetent patients’ who are conscious and who are not in a persistent vegetative state. Hence, a definition of ‘palliative care’ is proposed to be included.

We are of the view that a definition of ‘palliative care’ must be introduced as follows:

- “‘palliative care’ includes
- (i) the provision of reasonable medical and nursing procedures for the relief of physical pain, suffering, discomfort or emotional and psycho-social suffering.
- (ii) the reasonable provision for food and water.”
- (h) There should be a definition of ‘medical practitioner’ (see sec. 2(g)). We are adopting the definition in the Medical Termination of Pregnancy Act, 1971.

It reads as follows:

“‘medical practitioner’ means a medical practitioner who possesses any recognized medical qualification as defined in clause (h) of

section 2 of the Indian Medical Council Act, 1956 (102 of 1956) and who is enrolled on a State Medical Register as defined in clause (k) of that section.”

- (i) There needs to be a definition of ‘minor’ (see sec. 2(j)) as defined in the Indian Majority Act, 1875 (4/1875) because a patient who is a minor is ‘incompetent’.

“‘minor’ means a person who, under the provisions of an Indian Majority Act, 1875 (4 of 1875) is to be deemed not to have attained majority.”

- (j) For the reasons stated in the last chapter, we propose to declare ‘Advance Medical Directives’ as well as ‘Medical Powers of Attorney’ (Living Will) void for the reasons given in Chapter VII and hence both of these need to be defined. (see sec. 2(a) and sec. 2(h))

‘Advance Medical Directive’ is to be defined as follows:

“‘advance medical directive’ (called living will) means a directive given by a person that he or she, as the case may be, shall or shall not be given medical treatment in future when he or she becomes terminally ill.”

‘Medical Power of Attorney’ is to be defined as follows:

“‘medical power-of-attorney’ means a document executed by a person delegating to another person (called a surrogate), the authority to take decisions in future as to medical treatment which has to be given or not to be given to him or her if he or she becomes terminally ill and becomes an incompetent patient.”

Section 4 of the proposed Bill states that the Advance Medical Directive and the Medical Power of Attorney being void and of no effect and shall not be binding on the medical practitioner.

4) We next come to the substantive provisions of the proposed Bill.

Obviously, the first thing that is to be declared is that every ‘competent patient’, who is suffering from terminal illness has a right to refuse medical treatment (as defined i.e. including artificial nutrition and respiration) or the starting or continuation of such treatment which has already been started. (sec. 3(1))

If such informed decision is taken by the competent patient, it is binding on the doctor. (see sec. 3(2))

At the same time, the doctor must be satisfied that the decision is made by a competent patient and that it is an informed decision. Such informed decision must be one taken by the competent patient independently, all by himself i.e. without undue pressure or influence from others. This aspect will be contained in the proviso to sec. 3(2).

It must also be made clear that the doctor, notwithstanding the withholding or withdrawal of treatment, is entitled to administer palliative care i.e. to relieve pain or suffering or discomfort or emotional and psychological suffering to the incompetent patient (who is conscious) and also to the competent patient who has refused medical treatment. (sec. 9)

5) We next come to (a) 'incompetent patients' and (b) competent patients whose decisions are not informed ones, in respect of whom the doctor is entitled to take a decision for withholding or withdrawal of medical treatment provided it is in the 'best interests' of the patient. (sec. 5)

Here it is necessary to be very careful so that appropriate decisions are taken and the Act is not abused. We propose to provide that the doctor shall not withhold or withdraw treatment unless he has obtained opinion of a body of three expert medical practitioners from a panel prepared by high ranking Authority. Such a safeguard is necessary in view of the judgment in Bolam. We also wish to provide that where there is a difference of opinion among the three experts, the majority opinion shall prevail. (sec. 6)

We are also providing that the medical practitioner shall consult the parents or close relatives (if any) of the patient but that their views shall not be binding on the medical practitioner because it is the prerogative of the medical practitioner to take a clinical decision on the basis of expert medical opinion. (see sec. 5(2))

We also propose another important caution, namely, that the decision to withhold or withdraw must be based on guidelines issued by the Medical Council of India as to the circumstances under which medical treatment in regard to the particular illness or disease, could be withdrawn or withheld. Of course, these guidelines must be consistent with the provisions of the proposed Act. (see sec. 5(2) and sec. 14)

We propose in sec. 14 that it will be necessary for the Medical Council of India to issue guidelines. (The Medical Council of India could consult other expert bodies dealing with critical care such as the Indian Society for Critical Care Medicine which has also issued several guidelines and which, in fact, has requested us to prepare a Report on the subject). The guidelines are to be published in the Gazette of India and on the website of the Medical Council of India.

The attending physician cannot choose experts of his own choice. Here too one has to be careful to see that the experts are duly qualified and have necessary experience. It is, therefore, proposed that the attending physician must choose from a panel prepared by a recognized public authority. This is necessary to ward off complaints of abuse of the system. (sec. 7)

We propose that the panel of experts must be prepared and published by the Director General of Health Services, Central Government for purposes of the Union Territories and by the Directors of Medicine (or authorities holding equivalent posts) in the States. The panel must contain names of medical experts in different fields who can take decisions on

withholding or withdrawing medical treatment. The experts must have at least 20 years experience and must be of good repute. Those who are subject to disciplinary proceedings or who are found guilty of professional misconduct should not be included by the above Authorities in such panels. But, once the panels are prepared, in our view, the selection of the three experts must be left to the attending medical practitioner. (sec. 7)

The location of the place of treatment will define the appropriate panel of the relevant State or Union Territory for purposes of selection of experts by the attending medical practitioner. (sec. 7)

The panel prepared by the above Authorities will be published in the Official Gazette of the Government of India or of the concerned State, as the case may be and also on their respective websites. (sec. 7)

It shall be necessary for the Medical Practitioner to maintain a register where he obeys the patient's refusal to have the medical treatment or where, in the case of (i) competent or incompetent patient or (ii) a competent patient (who has or has not taken an informed decision) he takes a decision to withhold or withdraw or starting or continuance of medical treatment, he must refer to all these matters in the register. The register shall contain the reasons as to why he thinks the patient is competent or incompetent, or what the experts have opined, as to why he thinks the medical treatment has to be withheld or withdrawn in the best interests of the patient. He must also record age, sex, address and other particulars of the patient or the expert advice given under sec. 6 from the panel referred to in section 7.

Before withholding or withdrawing medical treatment under sec 5, in the case of incompetent patients and patients who have not taken an informed decision, the medical practitioner, shall inform in writing to the patient (if he is conscious), parents or relatives, about the decision to withhold or withdraw medical treatment in the patient's best interests.

Where such patients, parents or relatives inform the medical practitioner of their intention to move the High Court under sec 14, the medical practitioner shall postpone such withholding or withdrawal for fifteen days and if no orders are received from the High Court within that period, he may proceed with the withholding or withdrawing of the medical treatment.

A photocopy of the pages of the register should be lodged immediately with the Director General of Health Services or the Director of Medical Services of the concerned State where the treatment is being given or proposed or is proposed to be withheld or withdrawn, and acknowledgment obtained. The contents of the register shall be kept confidential and not revealed to the public or media.

The said authorities shall also maintain these photocopies in a register but shall keep the information confidential and shall not reveal the same to the public or media.

The said authorities may make rules for the purposes of sections 7 and 8 and publish the same in the appropriate Gazette.

6) We then come to the crucial provisions of the proposed Bill which will protect the patient in his decision for withholding or withdrawing medical treatment and thereby allowing nature to take its own course. A patient who takes a decision for withdrawal or withholding medical treatment has to be protected from prosecution for the offence of ‘attempt to commit suicide’ under sec. 309 of the Indian Penal Code, 1860. This provision is by way of abundant caution because it is our view, as stated in the last chapter, that the very provisions are not attracted and the common law also says that a patient is entitled to allow nature to take its own course and if he does so, he commits no offence. (sec. 10)

Likewise, the doctors have to be protected if they are prosecuted for ‘abetment of suicide’ under sections 305, 306 of the Penal Code, 1860 or of culpable homicide not amounting to murder under sec. 299 read with sec. 304 of the Penal Code, 1860 when they take decisions to withhold or withdraw life support and in the best interests of incompetent patients and also in the case of competent patients who have not taken an informed decision. Similarly, where doctors obey instructions of a competent patient who has taken an informed decision for withholding or withdrawing treatment, they should be protected. The hospital authorities should also get the protection. This provision is also by way of abundant caution and, in fact, we have pointed out in the last chapter that the doctors are not guilty of any of these offences under the above sections read with sections 76 and 79 of the Indian Penal Code as of today. Their action clearly falls under the exceptions in the Indian Penal Code, 1860.

We are also of the view that the doctors must be protected if civil and criminal actions are instituted against them. We, therefore, propose that if the medical practitioner acts in accordance with the provisions of the Act while withholding or withdrawing medical treatment, his action shall be deemed to be ‘lawful’. (sec. 11)

Our proposal to treat the doctor’s action, in the circumstances mentioned in the Act, as “lawful” requires, as a condition to be satisfied, namely, that the doctor maintains a register as to why he thinks a patient is competent or incompetent, or why a competent patient’s decision is an informed one, what the opinion of the three experts is, and why withholding or withdrawing medical treatment is in the best interests according to experts and himself. Maintenance of such record is mandatory and if such record is not maintained, the protection afforded under this Act is not applicable to him. We are proposing this provision to provide transparency and to have necessary evidence as to why the doctor has acted in a particular manner so that the Act is not abused. (sec. 8)

7) In the United Kingdom and other common law countries, the patient, parents or close relatives are entitled to seek declaratory relief in Courts for preventing the doctors or hospitals from withholding or withdrawing medical treatment or sometimes for directing such withholding or withdrawal.

Such declaratory relief is granted in UK and other common law countries when approached by doctors and hospitals where they are of the

opinion that it is necessary to withhold or withdraw medical treatment. They seek a declaration that such action be declared 'lawful'.

However, in Airedale (1993), the House of Lords and in Burke (2005), the Court of Appeal made it clear that it is not necessary in every case for the doctors to seek a declaration that the proposed action is lawful. Till a body or precedent is obtained, the medical profession may approach the Courts so that Courts will lay down what is 'good medical practice' in medical parlance. It was also so stated by Thomas J in the New Zealand case referred to by us (Auckland Area Health Board v. AG) (1993). This has already been done in UK.

These principles are, therefore, proposed to be substantially incorporated in the proposed Act. Therefore, we are of the view that only an 'enabling' provision is necessary in this behalf but not a provision which requires a declaratory relief to be obtained mandatorily in every case where the medical treatment is proposed to be withheld or withdrawn. The High Court has to dispose of the original petition in the light of the provisions of the proposed Bill. (sec. 12)

We are also of the view that time is essence in the case of terminally ill patients when decisions have to be taken under this enabling provision for withholding or withdrawing treatment. To avoid delays and appeals, the Court which deals with these cases must, therefore, be a Division Bench of the High Court and not the ordinary trial Courts. The Division Bench must deal with the matters with the greatest speed but, at the same time, after hearing all concerned and after due consideration. In England, we

find decisions are given sometimes almost immediately, soon after notices are served and the declaration is given in 2 or 3 days. Sometimes, reasons are given later. Therefore, we propose that these petitions be filed before a Division Bench of a High Court and should be disposed of within a maximum period of one month. We propose a provision for the High Court to call for further expert evidence or to examine further witnesses. The High Court can also appoint an amicus curiae. The High Court may even pass orders first and give reasons later. The High Court will be the High Court within whose territorial jurisdiction the medical treatment is proposed to be given or given or withheld or withdrawn.

There is yet another aspect debated in other countries. The question is whether once a declaration is given by the Division Bench of the High Court that such withholding or withdrawal is 'lawful', should it be binding on the civil and criminal Courts in subsequent proceedings. We have referred to a view of the House of Lords and of the other countries that such declarations are not binding, at any rate, on criminal Courts. We have seen that in New Zealand judgment decided by Thomas J in Auckland Area Health Board v. AG (1993), the learned Judge gave a declaration that no criminal offence is committed under the particular section of the New Zealand Criminal Code.

The High Court could be approached by the patient, parents, relatives, doctors or hospitals. The Court could hear all, including the next friend or guardian ad litem as also the amicus curiae.

The declaration given by the High Court must benefit the patient, the medical practitioner and the concerned hospital also.

According to our law of precedents, where there is already a decision of a Division Bench of the High Court declaring the proposed action of withholding or withdrawing medical treatment as lawful, such decisions of the High Court are binding on the subordinate Courts, civil and criminal. In order to prevent harassment in fresh litigation, we propose to make a statutory provision that once a declaration is given by the Division Bench of the High Court, that the action is lawful, it will be binding in subsequent proceedings, civil and criminal. This is permissible because the judgments of Division Benches of High Court are binding precedents on all trial Courts, civil and criminal. (sec. 12)

10)(a) There must be a provision preserving the privacy rights of patients and the confidentiality of professional advice. Once a petition is filed in the High Court by patients, parents or relatives or doctors or hospitals, the High Court must soon pass an order for keeping the identity of all persons, including doctors, experts, hospital confidential. In the proceedings of Court or in publications in the law reports or media, the identity of the persons or hospital will not be disclosed and they will have to be described by English alphabet letters as assigned by the High Court. This prohibition holds good during the pendency of the petition in the High Court and even after it is disposed of.

However, when the Court communicates its directions or decisions to the patient, doctor or hospital or experts, it will be necessary to disclose real

identity of patient and others. In such situations, the Court communications shall be in sealed covers. (sec. 13)

We also propose that if any person or body breaches the above provisions as to confidentiality, the High Court may take action for contempt of Court. (sec. 13)

(b) Even where the matter has not gone to the High Court, no person or body including the media can publish the identity of the patient, doctor, hospital, relatives or experts etc. and must keep identity confidential. If that is breached, they may be liable for civil or criminal action.

11) As stated earlier, while dealing with sections 5 and 7, there must be provisions mandating the Medical Council to issue guidelines on the question of withholding or withdrawing medical treatment to competent or incompetent patients suffering from terminal illness. It may consult experts and also experts in critical care medicine, before formulating the guidelines. We are also providing that it can modify the same from time to time, and they be published in the Official Gazette. (sec. 14)

The above recommendations find place in the draft Bill prepared by us and the Draft Bill is contained in the Annexure to this Report.

In the preparation of this Report, we place on record the important suggestions given by Sri S. Muralidhar, Part-time Member of the Law Commission.

We recommend accordingly.

(Justice M. Jagannadha Rao)  
Chairman

(K.N. Chaturvedi)  
Member-Secretary

Dated: 31<sup>st</sup> March, 2006

**Annexure****The Medical Treatment of Terminally ill Patients  
(Protection of Patients and Medical Practitioners) Bill, 2006**

A Bill to provide for the protection of patients and medical practitioners from liability in the context of withholding or withdrawing medical treatment including life support systems from patients who are terminally ill.

Be it enacted in the Fifty Seventh Year of the Republic of India as follows:

1. Short title, extent and commencement: (1) This Act may be called the Medical Treatment of Terminally ill Patients (Protection of Patients and Medical Practitioners) Act, 2006.

(2) It extends to the whole of India except the State of Jammu and Kashmir.

(3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

2. Definitions: unless the context otherwise requires,

- (a) ‘advance medical directive’ (called living will) means a directive given by a person that he or she, as the case may be, shall or shall not be given medical treatment in future when he or she becomes terminally ill.
- (b) ‘best interests’ include the best interests of a patient
- (i) who is an incompetent patient, or
  - (ii) who is a competent patient but who has not taken an informed decision, and
- are not limited to medical interests of the patient but include ethical, social, moral, emotional and other welfare considerations.
- (c) ‘competent patient’ means a patient who is not an incompetent patient.
- (d) ‘incompetent patient’ means a patient who is a minor or person of unsound mind or a patient who is unable to
- (i) understand the information relevant to an informed decision about his or her medical treatment;
  - (ii) retain that information;
  - (iii) use or weigh that information as part of the process of making his or her informed decision;
  - (iv) make an informed decision because of impairment of or a disturbance in the functioning of his or her mind or brain; or
  - (v) communicate his or her informed decision (whether by speech, sign, language or any other mode) as to medical treatment.

- (e) 'informed decision' means the decision as to continuance or withholding or withdrawing medical treatment taken by a patient who is competent and who is, or has been informed about
  - (i) the nature of his or her illness,
  - (ii) any alternative form of treatment that may be available,
  - (iii) the consequences of those forms of treatment, and
  - (iv) the consequences of remaining untreated.
  
- (f) 'Medical Council of India' means the Medical Council of India constituted under the Indian Medical Council Act, 1956 (102 of 1956).
  
- (g) 'medical practitioner' means a medical practitioner who possesses any recognized medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956 (102 of 1956) and who is enrolled on a State Medical Register as defined in clause (k) of that section.
  
- (h) 'medical power-of-attorney' means a document executed by a person delegating to another person (called a surrogate), the authority to take decisions in future as to medical treatment which has to be given or not to be given to him or her if he or she becomes terminally ill and becomes an incompetent patient.
  
- (i) 'medical treatment' means treatment intended to sustain, restore or replace vital functions which, when applied to a patient suffering

- from terminal illness, would serve only to prolong the process of dying and includes
- (i) life-sustaining treatment by way of surgical operation or the administration of medicine or the carrying out of any other medical procedure and
  - (ii) use of mechanical or artificial means such as ventilation, artificial nutrition and hydration and cardiopulmonary resuscitation.
- (j) ‘minor’ means a person who, under the provisions of an Indian Majority Act, 1875 (4 of 1875) is to be deemed not to have attained majority.
- (k) ‘palliative care’ includes
- (i) the provision of reasonable medical and nursing procedures for the relief of physical pain, suffering, discomfort or emotional and psycho-social suffering.
  - (ii) the reasonable provision for food and water.
- (l) ‘Patient’ means a patient who is suffering from terminal illness.
- (m) ‘terminal illness’ means
- (i) such illness, injury or degeneration of physical or mental condition which is causing extreme pain and suffering to the patients and which, according to reasonable medical opinion, will inevitably cause the untimely death of the patient concerned, or

- (ii) which has caused a persistent and irreversible vegetative condition under which no meaningful existence of life is possible for the patient.
3. Refusal of medical treatment by a competent patient and its binding nature on medical practitioners:

- (1) Every competent patient has a right to take a decision
- (i) for withholding or withdrawing of medical treatment to himself or herself and to allow nature to take its own course, or
- (ii) for starting or continuing medical treatment to himself or herself.
- (2) When a patient referred to in subsection (1) communicates his or her decision to the medical practitioner, such decision is binding on the medical practitioner

Provided that the medical practitioner is satisfied that the patient is a competent patient and that the patient has taken an informed decision based upon a free exercise of his or her free will.

4. Advance Medical Directives as to medical treatment and Medical Power of Attorney to be void and not binding on medical practitioner:

Every advance medical directive (called living will) or medical power-of-attorney executed by a person shall be void and of no effect and shall not be binding on any medical practitioner.

5. Withholding or withdrawing of medical treatment by medical practitioner in relation to a competent patient who has not taken an informed decision and in relation to an incompetent patient:

(1) Subject to compliance of the provisions of section 6, a medical practitioner may take a decision to withhold or withdraw medical treatment

(a) from a competent patient who has not taken an informed decision, or

(b) from an incompetent patient,

provided that the medical practitioner is of the opinion that the medical treatment has to be withheld or withdrawn in the best interests of the patient.

(2) The medical practitioner shall, while taking a decision under subsection (1),

(a) adhere to such guidelines as might have been issued by the Medical Council of India under section 14 in relation to the circumstances under which medical treatment to a patient in respect of the particular illness could be withheld or withdrawn, and

(b) consult the parents or relatives (if any) of the patient but shall not be bound by their views.

6. Expert medical opinion to be obtained by medical practitioner for purposes of section 5:

(1) No decision to withhold or withdraw medical treatment in respect of patients referred to in section 5 shall be taken by any

medical practitioner unless such medical practitioner has consulted and obtained the opinion in writing of three medical practitioners selected by him from the panel of medical experts referred to in section 7, who are experts in relation to the illness of the patient and unless the majority opinion of the experts is in favour of withholding or withdrawing the medical treatment.

(2) Where there is difference in the opinion of the three medical experts, the majority opinion shall prevail.

7. Authority to prepare panel of medical experts for purposes of section 6:

(1) The Director General of Health Services, Central Government and the Director of Medical Services (or officer holding equivalent post) in each State shall, prepare a panel of medical experts for purposes of section 6.

(2) The panels referred to in subsection (1) shall include medical experts in various branches of medicine, surgery and critical care medicine.

(3) The medical experts referred to in subsection (1) shall be experts with not less than twenty years experience.

(4) While empanelling medical experts on the panels, the authorities mentioned in subsection (1) shall keep in mind the reputation of the expert and shall exclude from the panel, experts against whom disciplinary proceedings are pending with the State Medical Council concerned or the Medical Council of India and those experts who have been found guilty of professional misconduct.

- (5) The panels prepared under subsection (1) shall be published in the Official Gazette of the Central Government or the Official Gazette of the State, as the case may be, and on the respective websites of the said authorities and the panels may be reviewed and modified by the authorities specified in subsection (1) from time to time and such modifications shall also be published in the Gazettes as aforesaid, or on the websites, as the case may be.
- (6) The relevant panel for selection of experts will be the panel for the State or Union Territory in which the medical treatment is being given or is proposed or is proposed to be withheld or withdrawn.
8. Medical Practitioner to maintain register and inform patient, parents etc:
- (1) The medical practitioner who is bound to follow the decision of a competent patient given under section 3 or who takes a decision under section 5, shall maintain a record in a register as to why he is satisfied that
- (a) the patient is competent or incompetent;
  - (b) the competent patient has or has not taken an informed decision about withholding or withdrawing or starting or continuance of medical treatment;
  - (c) the best interests of an incompetent patient or of a competent patient who has not taken an informed decision, require medical treatment to be withheld or withdrawn; and
- shall maintain record of age, sex, address and other particulars of the patient and as to the expert advice received by him under section 6

from the three experts selected by him out of the panel referred to in section 7.

- (2) Before withholding or withdrawing medical treatment under sec 5, the medical practitioner shall inform in writing the patient (if he is conscious), his parents or other relatives or guardian about the decision to withhold or withdraw such treatment in the patient's best interests.
- (3) Where the patient, parents or relatives stated in subsection (2) inform the medical practitioner of their intention to move the High Court under sec 14, the medical practitioner shall postpone such withholding or withdrawal by fifteen days and if no orders are received from the High within that period, he may proceed with the withholding or withdrawing of the medical treatment.
- (4) A photocopy of the pages in the register with regard to each such patient shall be lodged immediately, as a matter of information, on the same date, with the Director General of Health Services or the Director of Medical Services of the Union Territory or State, as the case may be, in which the medical treatment is being given or is proposed or is proposed to be withheld or withdrawn and acknowledgement obtained and the contents of the register shall be kept confidential by the medical practitioner and not revealed to the public or media.
- (5) The authorities referred to in subsection (2) shall on receipt of such photo copies, maintain the said photocopies in a register in the offices of the

said authorities and shall keep the information confidential and shall not reveal the same to the public or the media.

(6) The said Authorities may make Rules for the purposes of sections 7 and 8 and publish the said Rules in the appropriate Gazette or on their websites.

9. Palliative care for competent and incompetent patients:

Even though medical treatment has been withheld or withdrawn by the medical practitioner in the case of competent patients and incompetent patients in accordance with the provisions of sections 3, 5 and 6, such medical practitioner is not debarred from administering palliative care.

10. Protection of competent patients from criminal action in certain circumstances:

Where a competent patient refuses medical treatment in circumstances mentioned in section 3, notwithstanding anything contained in the Indian Penal Code (45 of 1860), such a patient shall be deemed to be not guilty of any offence under that Code or under any other law for the time being in force.

11. Protection of medical practitioners and others acting under their direction, in relation to competent and incompetent patients:

Where a medical practitioner or any other person acting under the direction of the medical practitioner withholds or withdraws medical treatment,

(a) in respect of a competent patient, on the basis of the informed decision of such patient communicated to the medical practitioner for such withholding or withdrawal, or

(b) (i) in respect of a competent patient who has not taken an informed decision, or

(ii) in respect of an incompetent patient,

and the medical practitioner takes a decision in the best interests of the patient for withholding or withdrawal of such treatment,

such action of the medical practitioner or those acting under his direction, and of the hospital concerned, shall be deemed to be lawful, provided only where the medical practitioner has complied with the of sections 5, 6 and 8.

12. Enabling provision for seeking declaratory relief before a Division Bench of the High Court:

(1) Any patient or his or her parents or his or her relatives or next friend may move an original petition before a Division Bench of the High Court seeking a declaration that any act or omission or proposed act or omission by the medical practitioner or a hospital in respect of withholding or withdrawing medical treatment from a patient is lawful or unlawful and seeking such interim or final directions from the said Court as they may deem fit.

Explanation: ‘High Court’ in this section and section 13 means the High Court within whose territorial jurisdiction the treatment is being given or is proposed or proposed to be withheld or withdrawn.

- (2) Any medical practitioner or a hospital may move an original petition before a Division Bench of the High Court seeking a declaration that any act or omission or proposed act or omission by the medical practitioner or the hospital in respect of withholding or withdrawing medical treatment from a patient is lawful and seek such interim or final directions from the said Court as he or it may deem fit.
- (3) The Division Bench of the High Court may, wherever it deems it necessary, appoint an amicus curiae to assist the Court and where a patient is unrepresented, direct legal aid to be provided to such patients.
- (4) The Division Bench of the High Court shall dispose of such petitions in the light of the provisions of this Act, after hearing the patient if he or she is competent or hearing his or her parents or relatives or next friend or guardian-ad-litem, the medical practitioners or the hospital authorities treating the patient and the amicus curiae, if any, and after receiving, wherever necessary or appropriate, such further evidence of witnesses including expert medical practitioners.
- (5) Such original petitions shall be disposed of expeditiously and, at any rate, within a period of thirty days from the date of filing of the original petition.

- (6) Where the High Court is of the view that interim or final directions have to be passed and implemented urgently, it may pass such operational orders initially and follow up the same by giving its reasons therefor, soon thereafter.
  - (7) Any declarations or final directions given by the Division Bench of the High Court in a petition filed under subsection (1) or (2) shall be binding in all other actions civil or criminal against the medical practitioner or the hospital, in relation to the said act or omission of the medical practitioner or the hospital, in relation to the said patient.
  - (8) Recourse to the High Court for a declaratory relief and for directions under this section is not a condition precedent for withholding or withdrawing medical treatment if such withdrawal or withholding is done in accordance with the provisions of this Act.
13. Confidentiality for purposes of sections 12 and 13:
- (1)(i) The Division Bench of the High Court shall, whenever a petition under section 12 is filed, direct that the identity of the patient and of his or her parents, the identity of the medical practitioner and hospitals, the identity of the medical experts, referred to in section 6, or of other experts or witnesses consulted by the Court or who have given evidence in the Court, shall, during the pendency of the petition, and after its disposal, be kept confidential and shall be referred only by the English alphabets as stated in clause (ii)..

- (ii) As soon as the original petition is filed, the Division Bench of the High Court shall make an order choosing English alphabets for identifying the patient, parents, doctors, hospitals or experts or other witnesses referred to in sub clause (i) or other persons connected with the medical treatment and shall direct that in the further proceedings of the Court or in any publications in the law reports or in the print or electronic media or audio-visual media, during and after disposal of the petition, those alphabets alone shall be used to refer to the particular patient, person or hospital and that the identity of the patient, person or hospital shall not be disclosed and the High Court may, where necessary, hold all or any part of the hearing in camera.
- (iii) It shall not be lawful for any person or body to refer to the identity of the patient, person or hospital or other particulars or matters referred to in sub clause (i) and (ii) in any law-report or publication in the print or electronic or audio-visual media, and the alphabets designated by the Division Bench of the High Court under subsection (2) alone shall be referred to while publishing the proceedings of the Court, during the pendency of the petition and after its disposal.
- (iv) Any person or body acting in violation of the provisions of sub clause (iii) may be held liable for contempt of Court for violation of the orders of Court under sub clause (ii) and be dealt with accordingly.
- (v) Notwithstanding the provision of clauses (i) to (iv), when the declarations or directions given by the High Court have to be communicated to the patient, parents, medical practitioner, hospital or

experts concerned, it shall be permissible to refer to the true identity of the patient, persons or hospital and such communications shall be made in sealed covers to be delivered to these addresses so that the declarations or directions made by the High Court are understood and implemented as being with reference to the particular patient.

(vi) The High Court may make Rules of Procedure for the implementation of provisions of section 12 and this section.

(2) No person or body including media shall, in cases which have not gone to the High Court under subsection (1), publish the names of the patients or other information which may disclose the identity of the patient, relatives, doctor, hospital or experts and if these provisions are violated, may be proceeded against by way of a civil or criminal action in accordance with law.

14. Medical Council of India to issue Guidelines:

(1) Consistent with the provisions of this Act, the Medical Council of India shall prepare and issue guidelines, from time to time for the guidance of medical practitioners in the matter of withholding or withdrawing of medical treatment to competent or incompetent patients suffering from terminal illness.

(2) While preparing such guidelines, the Medical Council of India may consult medical experts or bodies consisting of medical practitioners who have expertise in relation to withholding or

withdrawing medical treatment to patients or experts or bodies having experience in critical care medicine.

(3) The Medical Council of India may review and modify the guidelines from time to time.

(4) The guidelines and modifications thereto, if any, shall be published in the Official Gazette of India and on its website.

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