

The law, death, and medical ethics

Mrs Pretty and Ms B

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Was society's response adequate in the cases of Mrs Pretty and Ms B?

On the 11th of May, less than two weeks after losing her final legal appeal, Mrs Diane Pretty died, under sedation and in the care of a hospice. It was not the end she had pursued through the English High Court, the Court of Appeal, the House of Lords, and the European Court of Human Rights. Paralysed by motor neurone disease and unable to take her own life, Mrs Pretty wanted her husband to be allowed to help her to die when they decided the time had come. But in England, assisting suicide is a crime, although suicide itself no longer is, and the English courts refused Mrs Pretty's request to grant her husband legal immunity. In turning to the European Court of Human Rights, Mrs Pretty argued that the English courts' refusal had violated the European Convention on Human Rights.

The European court, however, judged that there had been no violation. The right to life (article 2 of the convention) could not be construed as conferring a "right to die", and consequently the state could not be required to "sanction actions intended to terminate life" in order to protect Mrs Pretty from the "inhuman or degrading treatment" (prohibited by article 3) to which she claimed the law on assisted suicide subjected her. The right to respect for private life (article 8), moreover, had to be exercised "in accordance with the law" of the state concerned. "States were entitled to regulate through the operation of the general criminal law activities which were detrimental to the life and safety of other individuals"; and such activities were what the English law against assisting suicide was designed to prevent. Exceptions to this law could not be allowed without undermining the protection it afforded to "the weak and vulnerable".¹

Mrs Pretty's case appears to have presented society with a tragic dilemma, in which whatever is done or not done, some important value is violated, and someone must suffer severely. The European court seems to have recognised this when it stated that it "could not but be sympathetic to the applicant's apprehension that without the possibility of ending her life she faced the prospect of a distressing death".¹ There was perhaps one way in which the dilemma might

have been avoided, or at least palliated. In their classic analysis of tragic choices, Calabresi and Bobbitt observe that one important value "capable of being abandoned with regard to some questions without being destroyed everywhere" is honesty.² In Mrs Pretty's case, the European court noted, the UK government "had stated that flexibility was provided for in individual cases by the fact that consent was needed from the DPP (Director of Public Prosecutions) and by the fact that a maximum sentence was provided, allowing lesser penalties to be imposed as appropriate".¹ Had Mr Pretty assisted his wife to die, that is, he would not necessarily have been prosecuted, and if he had been prosecuted and found guilty, his penalty would not necessarily have been more than nominal. But this option, although presumably they were aware of it, was not chosen by Mr and Mrs Pretty. By deciding not to sacrifice honesty as they understood it, and by doing so very publicly, they made the moral issues raised by the case very difficult to avoid.

The moral issues were made more acute by the concurrent case, before the English High Court, of Ms B. Ms B, like Mrs Pretty was in her forties and paralysed, but unlike Mrs Pretty she was not terminally ill. She was, however, dependent on artificial ventilation, withdrawal of which would allow her to die; and the sole issue which the court had to determine, the presiding judge stated, was whether Miss B was competent to refuse treatment. The court decided that she was competent, and a month later, her ventilator was switched off and Ms B died peacefully in her sleep—on the same day that the European Court of Human Rights announced its decision in the case of Mrs Pretty.

In the eyes of the law, the different judgments in these two cases are not inconsistent. But as Peter Singer writes, in one of several commentaries in this edition of the journal on the case of Ms B, it seems absurd to the lay observer that there is "a right to refuse medical treatment, even if that means you will die, but no right for someone else to assist you to die, if the mere withdrawal of medical treatment will not bring about that end, or will not bring it about

in an acceptable manner". The underlying problem, Singer believes, is that we have built "legal doctrines based on two separate rules of law" (the competent adult's right to refuse treatment, and the prohibition of assisting suicide) "and thereby we have reached a situation that makes no ethical sense at all." The remedy for this is to "move beyond a rule-based ethics, and consider the consequences of the situations with which we are faced".³ Since the supposedly harmful consequences of legalising assisted suicide, he argues, in fact are no greater than those of respecting the right to withdrawal of treatment, Mrs Pretty's wishes, as much as Ms B's, ought to have been respected.

This conclusion receives indirect support, albeit under protest, from another commentary in this edition, written from a very different moral viewpoint. John Keown sees the law's role as defending "the fundamental principle of the sanctity or inviolability of life". But he is concerned that in the case of Ms B among others, "the courts have risked undermining the law's goal of protecting life by upholding a right to refuse treatment which seems so broad as to include a right to commit suicide and to be assisted in suicide by having treatment withheld or withdrawn".⁴ The courts have been able to uphold "an 'absolute' right to refuse treatment, for any reason or none", he argues, by regarding treatment withdrawal as an omission, rather than an act which could be interpreted as assisting suicide. But if the patient's or doctor's *intention* is to commit or assist suicide, it makes no moral difference whether this is achieved by an omission or by an act. By relying on the omission/act distinction, rather than by focusing on intention, the courts, in cases such as that of Ms B, have made it much more difficult to resist the increasingly popular force of consequentialist arguments, such as Singer's, in favour of allowing assisted suicide.

Keown's fears may be well founded. Even among doctors, who often find the omission/act distinction psychologically helpful, there are those, including some who cared for Ms B, who find it difficult to see how switching off a ventilator in such circumstances can be regarded as other than an act. Others too may share Keown's unease with the idea that the "absolute" right of a competent patient to refuse treatment, "exists notwithstanding that the reasons for making the choice are rational, irrational, unknown, or even non-existent".⁵ Difficult intellectual gymnastics have always been required to entertain the idea of "non-existent" or "irrational" reasons. A competent patient may have reasons for refusing treatment which are "unknown" in the sense that they cannot be communicated to others, or perhaps

even clearly articulated in the patient's own mind. A competent patient may also have reasons that others, or even the same patient in other circumstances, might consider "irrational" by their own or society's standards of reasonableness. But to be genuinely "irrational" is to be deprived of any reason whatever, and it is difficult to see how "reasons" can be "irrational" in this strict sense, or (what perhaps comes to the same thing) "non-existent", or again how having such "reasons" can be consistent with mental capacity. As another contributor to this edition, Marc Stauch, observes: "the competent patient who refuses life-saving treatment for no reason may be a legal oxymoron".⁶

The amount of attention given to Ms B's capacity, and in particular the judge's "extended and anxious inquiry into Ms B's reasons for wishing to discontinue ventilation in this case, apparently as a precondition for finding her competent", Stauch comments, "may be thought to give the lie to some of the more hard-edged *obiter dicta* from earlier case law in which it had been asserted that competent patients are entitled to refuse medical treatment (including life saving treatment) for no reason at all".⁶ This interpretation may help to assuage fears that the High Court's finding that Ms B had been treated unlawfully, gives any kind of legal encouragement to doctors who, fearing such action against themselves, are tempted to accede too quickly to the expressed wish to be allowed to die of a patient whose mental capacity may be in doubt. It does not, however, assuage fears of the kind expressed by Keown, that in cases of this kind, the English courts may be extending the "absolute" right of a competent patient to refuse treatment, not "because it is either futile or too burdensome" but "even to refusals of treatment which are clearly suicidal, where treatment is refused precisely with the intention (purpose) of putting an end to life".⁴

Keown's claim here perhaps might be answered with the argument that in Ms B's case, the reasons for refusal were indeed that the treatment was "futile and too burdensome", determinations which require to be made with reference to the patient's own judgment of futility and burdensomeness. But it is difficult to evade the conclusion that treatment was also refused "with the intention (purpose) of putting an end to life", which Keown characterises as "clearly suicidal". If Keown is

correct in this characterisation, and if the law's proper goal, as he claims, is "to discourage suicide, assisted suicide and murder", then the only way to evade the conclusion that judgments such as that in the case of Ms B are undermining this proper goal, may be to argue: that there are exceptional circumstances in which the intention of putting an end to (one's own) life can be morally justified; that such circumstances can be clearly distinguished from those in which the intention is not morally justified, and hence that putting an end to (one's own) life in these exceptional circumstances is not an example of what the law properly seeks to discourage. If such exceptional circumstances can be distinguished sufficiently clearly however, it may be difficult, given the problematic nature of the omissions/acts distinction, not to extend them to include circumstances such as those of Mrs Pretty.

This eventuality clearly is what Singer's consequentialist approach would approve. The worry about his approach, however, is not just Keown's, but also the concern expressed over a century ago by Sidgwick that traditional moral rules are easier to break down than new ones are to build up, and that utilitarian improvements on traditional moral rules may depend for their success on making moral distinctions that are too fine or complex for practical purposes.⁷ The latter view is reflected, for example, in the European court's response to Mrs Pretty's claim with reference to article 14 (prohibition of discrimination) of the European convention, "that the current law discriminated against her, as an able-bodied person would legally be able to commit suicide, whereas she could not without help". "Cogent reasons" the court stated, "existed for not seeking to distinguish between those who were able and those who were unable to commit suicide unaided". "The borderline between these two categories would often be a very fine one and to seek to build into the law an exemption of those judged to be incapable of committing suicide would seriously undermine the protection to life which the 1961 Act was intended to safeguard and greatly increase the risk of abuse."¹

A crucial question here therefore is whether the law, medicine, and society will ever be able to make moral distinctions that are sufficiently clear and stable to distinguish between those circumstances in which assisted suicide can and

cannot be justified. Doubts on this score are deepened by the need also to consider the broader social context in which such circumstances may arise. In a further contribution to this edition, Diane Coleman and Stephen Drake argue that the outcome, even of so carefully and sympathetically considered a case as that of Ms B, may have been influenced by unquestioned assumptions about the quality of life of people with severe physical disabilities and also by inadequate provision of resources.⁸ Thus, even if the powerful and increasingly popular arguments advanced by Singer and others in favour of allowing assisted suicide are accepted, and even if the law, medicine, and society can achieve a sufficiently clear and stable consensus on the particular circumstances in which assisted suicide can and cannot be justified, serious doubts remain about legalising assisted suicide in a social context where the rights of, and resources for, disabled people are less than fully recognised and provided. The price being paid for the present legal impasse, and the evident contradiction perceived in the public mind between the judgments in the cases of Ms B and Mrs Pretty, once again may be in terms of the sacrifice of honesty—not least about the fact that as a society we are not yet willing, or perhaps able, to rise to the challenge of what these two women had to suffer.

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