THE LAW, DEATH, AND MEDICAL ETHICS

The case of Ms B: suicide's slippery slope?

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J Med Ethics 2002;**28**:238–239

In the case of Ms B, the High Court ruled that as Ms B was a competent adult patient, her doctors acted unlawfully in overriding her refusal of life-preserving ventilation. This commentary considers whether this case supports the proposition that in English law the right to refuse treatment extends even to refusals which are clearly suicidal.

In February 2001 Ms B, who had become completely paralysed from the neck down, was placed on a ventilator.[1] Her later requests for it to be withdrawn were overridden. In April two psychiatrists at the hospital concluded that she was not competent to refuse the ventilation. In August an independent psychiatric reassessment concluded she was competent. Thereafter the hospital regarded Ms B as competent.

Nevertheless, her doctors continued to refuse to withdraw her ventilation. Drs C and R, her anaesthetists, could not bring themselves to contemplate that they should be part of bringing Ms B's life to an end by turning off her ventilator. They also felt that a spinal rehabilitation unit would be a better place for Ms B to make her decision than the intensive care unit she was in. Ms B made it clear she did not want to go to a spinal rehabilitation unit or to a hospice, since the hospice would not agree to withdraw her ventilation.

Ms B sought declarations from the High Court that she was competent to refuse life-prolonging medical treatment; that she had been since August 2001; that the hospital had therefore been treating her unlawfully since that time, and nominal damages for this trespass to her person.

The judge, Dame Elizabeth Butler-Sloss, president of the family division of the High Court, identified the central issue in the case as whether Ms B had been competent since August to refuse ventilation. Was Ms B, in other words, able to comprehend and retain the information material to the decision, especially as to the likely consequences of having or not having the treatment, and was she able to use the information and weigh it in the balance as part of the process of arriving at a decision? Much of the judgment comprises a review of the evidence bearing on this issue from Ms B and from medical and psychiatric experts.

Ms B said she had never changed her mind that she wanted the ventilator withdrawn and that it was only during the period when she was assessed as incompetent that she had agreed to consider alternatives. The judge concluded that Ms B was an "exceptionally impressive witness" who was extremely well informed about her condition, whose wishes were clear and well expressed, and who seemed to display a very high standard of mental competence. The judge also heard evidence from five doctors, including two more psychiatrists.

In finding that Ms B was indeed competent the judge started with the legal presumption that adults possess mental capacity. Although that presumption had been rebutted in respect of the period April to August 2001, the psychiatric assessment in August concluded Ms B was competent and that was reinforced by the further psychiatric evidence tendered to the court. No psychiatrist had suggested that she had not been competent since August 2001. Her Ladyship was "entirely satisfied" that Ms B was competent to make all relevant decisions about her medical treatment, including the decision to refuse ventilation; that she had been competent since the psychiatric reassessment in August 2001, and that she would remain competent for the foreseeable future. The judge therefore granted the declarations sought and made a nominal award of damages against the hospital for trespass to the person.

At first blush, the judge's reasoning in this case may seem ethically and legally uncontroversial. Few, if any, ethicists or lawyers would question a patient's right to refuse treatment because it is either futile or too burdensome. Did, however, the judge go further and uphold a more sweeping right to refuse treatment, one which extends even to refusals of treatment which are *clearly suicidal*, where treatment is refused *precisely with the intention (purpose) of putting an end to life*? If so, her reasoning is controversial. For: if the courts recognise a right to commit suicide by refusing treatment and allow or even require doctors intentionally to assist their patients to commit suicide thereby, the law's prohibition on actively assisting suicide is gravely undermined. What is the moral difference between intentionally assisting suicide by an omission and by an act?

Moreover, once the prohibition on active assisted suicide is undermined, the prohibition on the active, intentional termination of life is in turn weakened. What is the moral difference between intentionally and actively assisting suicide and intentionally and actively terminating life?

In this case, as in previous cases addressing the right to refuse treatment, the judge did indeed state the right in terms which appear sufficiently broad to include a right even suicidally to refuse treatment. The judge cited earlier cases which have asserted that competent adults have an "absolute" right to refuse treatment, for any reason or none. The judge nowhere denied that this "absolute" right extends to suicidal refusals.

She did, however, cite a passage from the speech of Lord Goff in the Tony Bland case. There,

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Accepted 20 May 2002

Lord Goff said that where a competent patient refuses life support there is no question of the patient having committed suicide nor therefore of the doctor having assisted the patient to commit suicide.[2] With respect, why not? Surely it all depends on the patient's *intention* in refusing life support and the doctor's *intention* in withdrawing it. If the patient refuses life support precisely with the intention of ending his or her own life, why is this not suicide? And if the doctor's purpose in switching off the life support is precisely to assist the patient to commit suicide, why is this not assisted suicide (if not murder)? It is unfortunate that these issues were not addressed by the judge in the case of Ms B. Was it sufficient to cite a passing comment by Lord Goff, and one evidently made without the benefit of any argument or authority on the point in question?

That the legal status of suicidal refusals was not discussed in the judgment is all the more surprising in view of the evidence suggesting that Ms B's intention *may* have been suicidal, that is, not to put an end to a burdensome treatment, but to put an end to her own life. Ms B said: "I find the idea of living like this intolerable"; "I will not recover in any way. That is not acceptable to me"; "I cannot accept myself as disabled and dependent . . .. The totality of dependence is intolerable".

Moreover, that the judge *may* have regarded Ms B's refusal as suicidal and held that she had a right to commit suicide in this way is suggested by the judge's observations that Ms B "valued the ventilator and her handicap as worse than being dead" and that: "One must allow for those as severely disabled as Ms B, for some of whom life in that condition may be worse than death. It is a question of values and . . . we have to try inadequately to put ourselves into the position of the gravely disabled person and respect the subjective character of experience". Reflecting the fundamental principle of the sanctity or inviolability of life, the goal of the law has long been to discourage suicide, assisted suicide, and murder. Although suicide was decriminalised in 1961, this was in no way a condonation of suicide, much less recognition of a "right" to suicide, as the maintenance of the legal prohibition on assisted suicide confirmed. Yet in a line of recent cases,[3] including Ms B's, 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.

This is not to argue that the courts should always require doctors to override refusals of treatment which are suicidal. Nor is it to suggest that doctors who withdraw treatment which is suicidally refused necessarily do so with intent to assist suicide. It is, simply, to caution against judicial extension of the legitimate right to refuse futile or excessively burdensome treatments to include a right to commit suicide and assistance to do so. The right to refuse treatment should be regarded as a shield not as a sword. The courts should consistently hold that patients have no right to commit suicide by refusing treatment and that, whether or not doctors have a duty to prevent patients from committing suicide thereby, they certainly have a duty not intentionally to assist them.

REFERENCES

1 **Ms B v An NHS Hospital Trust**. www.courtservice.gov.uk/judgmentsfiles/j1075/B_v_NHS.htm
2 **Airedale NHS Trust v Bland [1993]** Appeal Cases 789 at 864.
3 **Discussed in Keown J**. *Euthanasia, ethics and public policy*. Cambridge: Cambridge University Press, 2002: 227–30. For a brief but impressive analysis of the law and ethics of suicidal refusals see Finnis JM. *Living will legislation*. In: Gormally L, ed. *Euthanasia, clinical practice and the law*. London: The Linacre Centre, 1994: 167–76.