NEW FELLOWS' LECTURE*

R.MacLean

INTRODUCTION BY THE PRESIDENT

Fellows, New Fellows,

It gives me great pleasure to introduce this evening's proceedings; I think we should call it the New Fellows' Lecture. A tremendous tradition has developed over the last few years when we have had really absolutely stunning pre New Fellows' Lectures, absolutely wonderful ones, and tonight we are particularly looking forward to Lord MacLean's contribution. Lord MacLean was educated at Inverness Royal Academy and then (perhaps) made the mistake of moving a little bit south to Fettes and, of course, became the Chairman of the Governors of Fettes in due course. I think you were called to the Bar in 1964 and then took silk in 1977. An extremely distinguished career much involved, as many of you will know, with the Piper Alpha Disaster Enquiry, and Chairman of the Criminal Lawyers Group of the Scottish Bar. Chairman presently of the Government Committee to report on the Treatment and Disposal of Serious and Violent Sexual Offenders, he is clearly a man of great distinction, but his highest distinction surely must be that he chairs the Scottish Football Association's Appeal Tribunal. Lord MacLean, we are looking forward to your lecture immensely.

Thank you.

THE HON. LORD MACLEAN'S SPEECH

President,

Thank you for your kind introduction. I am not at all sure that I justify the generous things you said about me. I am, however, conscious of a number of matters as I stand here in this magnificent lecture theatre.

Firstly, I am overwhelmingly conscious of the honour that this College has extended to me in inviting me to deliver this lecture, especially as I have just heard that you had stunning lecturers ahead of me.

Secondly, I noticed from the publication in the press of the list of New Fellows that amongst them was a solicitor who was well known to me, so he at least should know something about what I have to say, and, knowing him, I would expect him to be *reasonably* critical. Lord Mackay of Clashfern is also present, I am led to understand, and I would expect him to be *very* critical.

Thirdly, I should say that on the last occasion that I was in this lecture theatre you, President, introduced and welcomed my son as a member of this distinguished College.

Fourthly, since he delivered my granddaughter into this world, I owed it to the Social Convener to respond positively to his invitation to deliver this lecture. Indeed, as you will see in a moment, a considerable portion of this lecture concerns problems in part of his field of practice, namely that of obstetrics.

Lastly, I am fully aware that those whom I am addressing are sitting here captive but in eager anticipation of a sumptuous dinner, which I am led to understand will be available in the Great Hall well within the hour. I cannot say on my oath that this lecture will be much of an aperitif!

The right to life is the most fundamental of human rights. It is enshrined in Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms. These Convention rights have now formally been recognised in our domestic law in Scotland by the Human Rights Act 1998. New provisions giving individuals the right to challenge in court certain legislative provisions of the Scottish Parliament and decisions of members of the Scottish Executive have already been introduced by the Scotland Act 1998. These rights will be further extended when the full provisions of the Human Rights Act come into force later next year. Litigation is not, I readily accept, the best way to create an ethical code for doctors who are faced daily with decisions about life and death, and the best use of finite resources. Nevertheless, such decisions are too important in my view to be left to the private decision of individual doctors or even to the collective wisdom of the medical profession. The public, elected representatives, and the courts all have a legitimate interest. Public debate plainly is essential. In this lecture I wish to concentrate on the way in which the courts have been involved. I think it is important to realise that because of the new devolution structure in Scotland and the new human rights provisions, new challenges to doctors' decisions and new problems may be raised in the Scottish courts.

As no doubt many of you must know, every adult of sound mind is entitled to refuse medical treatment even when his or her own life depends upon receiving such treatment. This is simply a reflection of the individual's free will, or, as it has been judicially expressed, the autonomy of each individual and his right of self-determination. 'It is established' said Lord Goff in the case of *Airedale National Health Service Trust* v *Bland*[1], which arose, of course, as you know, after the Hillsborough Football Stadium Disaster in 1993:

> ...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 doctor responsible for his care must give effect to his wishes even though they do not consider it to be in his best interests to do so. To this extent, the principle of the sanctity of human life must yield to the principle of self determination, and, for present purposes perhaps more important, the doctor's duty to act in the best interest of his patient must likewise be qualified.

**Transcript of the Hon. Lord MacLean's lecture given for the New Fellows at the College on 24 September 1999.*

FIGURE 1
In clockwise order from top left: Professor Petrie, President of the Royal College of Physicians of Edinburgh; Professor Lawson, Vice President of the Royal College of Physicians of Edinburgh; the Rt Hon. Lord Mackay of Clashfern; the Hon. Lord Maclean.

In the case of *Re MB*[2] (to which I shall return shortly), Dame Elizabeth Butler-Sloss, giving the judgement of the Appeal Court, set out the principle thus: 'A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death.' The principle, you may think, is easily stated. General principles usually are. It is in their application that difficulties may arise.

This has in recent years, and predominantly throughout the 1990s, been well illustrated by a number of cases involving pregnant patients and their proposed treatment, such as Caesarean section operations which were considered medically by the obstetrician to be in the best interests of the mother and her unborn child who, be it noted, until birth has merely the status of a fetus. In other words, at least in layman's eyes, there would appear in this situation to be two interests, that of the mother and that of the fetus. I suspect that it is this consideration that has influenced the English judges in some of the earlier decisions which they reached in the last decade. As Lord Justice Thorpe has pointed out in an article in the *Family Law Reports* for October 1997, frequently those decisions were reached and had to be reached in conditions of great urgency. In *Re MB*, for example, the judge of first instance issued his declaratory orders at 9.55 pm at the conclusion of the hearing before him. By 11.00 pm the Court of Appeal had assembled. They heard full argument in open court and at 1.00 am they dismissed the appeal. This case may also be thought to illustrate the fact that, contrary to public opinion, senior judges do not enjoy leisured, comfortable and well-ordered lives!

First let me say something about the fetus in our law, and here I refer to both Scots and English Law. In a decision in 1992 the then Master of the Rolls, Lord Donaldson, said:

> An adult patient who suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it, or to choose one rather than another of the treatments being offered. The only possible qualification is a case in which the choice may lead to the death of a viable fetus. That is not the case here and even when it arises the courts will be faced with a novel problem of considerable legal and ethical complexity.

That qualification stated by Lord Donaldson, which was applied in a later case, has subsequently been doubted (see *Re MB* at p. 189 doubting the correctness of *Re S*).[3] An unborn child up to the moment of birth does not have any separate interests capable of being taken into account when a court has to consider an application in respect of a Caesarean section operation (see *Re MB*).[4] It does not have rights of its own at least until it is born and has a separate existence from its mother (see *Paton* v *British Pregnancy Service Trustees*).[5] This is how one of the most refined of recent judicial minds considered the nature of the fetus:

> There was, of course, an intimate bond between the fetus and the mother created by the total dependence of the fetus on the protective physical environment furnished by the mother, and on the supply by the mother through the physical linkage between them of the nutriments, oxygen and other substances essential to fetal life and development. The emotional bond between the mother and her unborn child was also of a very special kind, but the relationship was one of bond, not of

> identity. The mother and her fetus were two distinct organisms living symbiotically, not a single organism with two aspects. The mother's leg was part of the mother, the fetus was not. I would therefore reject the reasoning which assumes that since in the eyes of English law the fetus does not have the attributes which make it a person, it must be an adjunct of the mother. Eschewing all religious and political debate I would say that the fetus is neither. It is a unique organism. To apply to such an organism the principles of the law evolved in relation to autonomous beings is bound to mislead.

That is a quotation from the speech of Lord Mustill in the Attorney General's reference (number 3 of 1994) which the House of Lords decided in 1997.[6]

So following that through, Lord Justice Judge in the case of *St George's NHS Trust* v *X*[7] in 1998 said: 'Accordingly the interests of the fetus cannot be disregarded on the basis that in refusing treatment which would benefit the fetus a mother is simply refusing treatment for herself.' In that case the Court concluded thus: 'In our judgement, whilst pregnancy increases the personal responsibilities of a woman, it does not diminish her entitlement to decide whether or not to undergo medical treatment.' Although human and protected by the law in a number of different ways set out in the judgement in *Re MB*, an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends upon it. Her right is not reduced or diminished merely because a decision to exercise it may appear morally repugnant. Of course, cynics might say that in that case from which I have just quoted the opinion of Lord Justice Judge, the court could make such pronouncements and reach its decision the more easily because it was secure in the knowledge that the Caesarean section had been successfully carried out and that the mother had been delivered of a healthy baby girl, albeit that the court held that her treatment was unlawful because she had been unlawfully detained in hospital. I should add that it would appear from applications made to the European Commission on Human Rights in 1977 and 1981 that the right to life enshrined in Article 2 of the Convention will not be extended or applied to the unborn child, but that has not been the result of direct decision and so it remains to be seen how the present European Court on Human Rights will deal with the question, when, or if, it arises.

The moral tension which exists in these cases between the acknowledged right of the mother and the legally unacknowledged interest of the unborn child has been recognised by the courts and resolved, if it can be, by close consideration in each case of the mental capacity or competence of the mother to reach any decision relating to the consent necessary for treatment. In *Re C*[8] which was decided by Mr Justice Thorpe (as he then was) in 1994, he approved a three-stage test of mental competence in relation to the decision-making process - first, comprehending and retaining treatment information, second, believing it, and third, weighing it in the balance to arrive at a choice. This test was approved by the Court of Appeal in *Re MB* to which I have already referred.

I turn now to consider the facts of that case, however briefly, since they will, I think and I hope, be of interest to physicians generally. MB (the appellant) was aged 23. She was admitted to one of the respondent's hospitals on 14 February 1997. She was then 40 weeks pregnant and the fetus was in the breach position. She signed a consent form for a Caesarean section delivery but refused to consent to a venepuncture to provide necessary blood samples. She subsequently refused to consent to the insertion of the venflon necessary, of course as you know, for the anaesthetic to perform the Caesarean section delivery. She did agree to anaesthesia by mask but following an explanation to her of the risks attendant upon such a procedure, she withdrew her consent to it and also to Caesarean delivery. Four days later, on 18 February, she went into labour and agreed to delivery by Caesarean section providing that she did not feel the needle involved in the anaesthetic. Later that day in the operating theatre she refused to consent to anaesthesia by mask and the surgery was cancelled. The defendant Health Authority then sought and obtained from the judge of first instance a declaration that it would be lawful to perform a Caesarean section to deliver the fetus. MB instructed her lawyers to appeal that decision on the same evening as I have already said. On the following day she agreed to the induction of anaesthesia and she was delivered of a healthy male child by Caesarean section on 19 February 1997. The Court of Appeal, through Dame Elizabeth Butler-Sloss, who was in the chair, set out at some length six fundamental principles applicable to the question of the mother's capacity to decide. I often find that English judges over-elaborate what they mean to say, so that in the result they provide material which has to be construed and is usually picked over unnecessarily in later cases. But applying these principles the court found that the mother had consented to a Caesarean section. What she had refused to accept was the prick of the anaesthetist's needle, not the incision of the surgeon's scalpel. It was a case, therefore, of needle phobia. On the evidence before the court she was incapable of making any decision at all, so the court held. Because of her phobia she was suffering an impairment of her mental functioning which disabled her. Thus she was temporarily incompetent and the doctors were free to administer the anaesthetic if that were in her best interests.

Judging, no doubt - and here I hesitate in the presence of one of our most distinguished living judges - judging, no doubt, is all about reaching the right result more often than not. Judges are employed, believe it or not, for one purpose, and that is to apply sound judgement in the decisions which they reach. In this case I have little doubt that the right result was achieved but is the juridical basis correct? Do you think that the mother was temporarily incompetent? I wonder!

But if the patient suffers from no mental incapacity or impairment, and decides that treatment should be withheld, his or her wishes must be acceded to. This is well illustrated by two cases, one in England and one in Canada. In the English case of C, C was a schizophrenic patient in Broadmoor. In October 1993 Mr Justice Thorpe (as he then was) held that the patient in a lucid interval had refused in advance to consent to amputation made necessary because of peripheral vascular disease. That decision, the court held, should be respected.

The Canadian case I shall deal with in just a little more detail. It was a case of *Nancy B* v *Hôtel-Dieu de Quebec* and it was decided in 1992. Nancy B was 25 years of age and suffered from ascending motor paralysis caused by the

Guillain Barré Syndrome. It is well known to me because my mother suffered from it in her seventies and survived it extraordinarily well, as she will tell you at the drop of a hat! She is 91 and going strong, I can tell you!

From the onset of her disease in June 1989 Nancy B had been intubated and on a respirator. This became essential as her respiratory muscles atrophied. In January 1991 she was informed that her condition was irreversible. As the months passed, she became more and more determined to stop the respiratory support treatment. Her intellectual faculties remained intact. Her suffering was not because of the underlying illness but because she was almost incapable of movement. With respiratory support she was capable of living for many years. The case came before Quebec Superior Court when Nancy sought an injunction against the hospital and her physician to require them to comply with the decision to stop the respiratory support. The hospital entered appearance but did not contest the claim. No appearance was entered on behalf of her physician. The judge made the Attorney General of Quebec a party to the action. The Judge, Mr Justice Dufour, heard oral evidence and medical evidence, and also the evidence about Nancy's views in relation to her treatment. The court attended at the hospital and satisfied themselves that Nancy's consent to stopping the respiratory support was real and enlightened. Having reviewed the development of the law relating to patient consent and the code of ethics of physicians applicable in Quebec, the court was satisfied that the obtaining of consent from a patient was essential. It followed as a logical corollary that the patient generally had a right not to consent, that is, the right to refuse treatment and to ask that it should cease. In cases where it has already begun Mr Justice Dufour was of the opinion that what Nancy was seeking, relying on the principle of personal autonomy and her right of self-determination, was that the respiratory support treatment being given her should cease so that nature might take its course. In order to do this, as she was unable to do this herself, she needed the help of a third person. The judge took the view that the conduct of a physician who in those circumstances stopped treatment did not denote wanton and reckless disregard. Having considered the various criminal court provisions, he concluded that stopping the treatment would not be a crime, including the crime of aiding suicide. The underlying rationale was that homicide and suicide were not natural deaths, whereas in the present case if the death took place after stopping respiratory support treatment, it would be the result of nature taking its course. Nancy was successful in her application. The court made an order to the effect that the attending physician was authorised to stop the respiratory support treatment when the plaintiff, Nancy, so desired, but the court required that her consent be checked again before that was done.

In some jurisdictions, however, relatives have sued in court seeking to prolong the life of a relative despite the clear medical advice that such treatment should cease. The American case of baby L illustrates this. She was a two-year old girl who was born very disabled after a difficult pregnancy and birth. Despite every medical effort her neurological condition remained very depressed with no responsiveness except to pain. She underwent a gastrostomy at the age of one month, a Nissen fundoplication at four months, and a tracheostomy at seven months. There were intermittent episodes of pulmonary aspiration and uncontrolled seizures. She was discharged after 14 months for 24-hour nursing care but was readmitted within two weeks for recurrent pneumonia. During the next several months she was repeatedly hospitalised for pneumonia and septic shock. She also had a history of four cardiopulmonary arrests. A meeting of health care personnel and the Ethics Committee was convened to discuss the advisability of reinstituting mechanical ventilation and cardiovascular support, when her condition again worsened at the age of 23 months. It was unanimously agreed that further medical intervention was not in her best interests and this would only subject her to additional pain without affecting the underlying condition or the ultimate outcome. The mother rejected the opinion and insisted that everything possible should be done to ensure the child's survival. She instructed an attorney who arranged a hearing in the Probate Court. In court, the physicians were asked what they would do if the judge issued an order for mechanical ventilation. The response was to the effect that, as the physicians believed it would violate their ethical obligation to the patient, they would decline to participate in such an action. The judge appointed a guardian *ad litem* for the child to assess the condition and make recommendations about care. In this case the judge was sympathetic to granting the mother's order but sought further information. The potential clash between the judge, had he been prepared to grant the order, and the physicians, who were not disposed to obey it for ethical reasons, was avoided, as the mother did not pursue the action further in court. Instead she transferred the child from the treating hospital to a different hospital where a physician was prepared to accommodate the mother's wishes. It appears that no attempt was made by the appointed guardian *ad litem* to enter the court proceedings and to argue on behalf of the child that the child had a right, despite the wishes of her mother, to be allowed to die.

Although I have highlighted some examples which illustrate the importance given to the right to life and respect for individual free choice, another question arises: in certain circumstances is there a right to die? This question has become more controversial because of the remarkable medical and scientific advances which have been made in this century, and certainly in the latter part of this century. As a result of such advances, life in many cases an be extended in circumstances where there is no, or very limited, quality of life. In the case of the mentally capable adult the doctrine of informed consent allows a patient to choose to stop treatment. But for many patients in a desperate medical condition, there is no possibility of obtaining consent. In such a case is a doctor entitled to cease any or all care in the knowledge that the patient will certainly die? Because of the uncertainties about the law such a case came before the Scottish Courts in 1996. In the case involving the Law Hospital National Health Service Trust[9] a patient in 1992 suffered from irreversible damage to the cerebral cortex and fell into a persistent vegetative state. The patient remained alive only because feeding and hydration were provided to her artificially, and because of the nursing care she received in hospital. Medical experts were of the opinion that her case was hopeless and that there were no useful avenues of treatment to explore. Lord Hope of Craighead who was then our Lord President said:

> Medical ethics must take account of the law, but it is not a sufficient reassurance for the doctor in the present state of the law to be told that his proposed conduct is medically ethical. He is entitled to be told whether his conduct will expose him to the risk of an action of damages for negligence, and he cannot ignore the risk that a prosecution may follow on the ground that his conduct amounted to murder or at least to culpable homicide (the Scots equivalent of manslaughter). I regard the Criminal Law as ill-suited to control the conduct of doctors in the exercise of their skill and judgement especially when they have acted in accordance with a practice accepted as proper by a competent body of professional opinion. This led the House of Lords in *Airedale NHS* v *Bland*[1] on grounds of public policy to decide that the court should by declaration provide to doctors faced with such decisions clear rulings as to whether the course which they proposed to adopt was or was not lawful.

The Court in Scotland took the view that in circumstances where the medical profession were unclear about the legal implications of their medical acts or omissions, they were entitled to look to the court for guidance. The court made it plain that it was not intended that in every case an application to the court had to be made where it was intended to withdraw treatment. In this case the Lord Advocate also made a public statement that there would be no prosecution.

The ethical dilemmas which arose in the Law Hospital case are compounded if the hopeless condition of the patient is the result of medical negligence for which the treating doctors are responsible. Obviously in such circumstances there may be a substantial claim for damages and the amount of the damages might depend on the life expectancy and costs of the care regimen of the patient. The shorter the life of the patient, the less will be the damages. In such a case the decision to terminate care, thus resulting in the death of the patient, would obviously be very difficult. That may be the reason, as I understand it, why such a case is presently being brought before the Scottish courts for consideration and decision.

The major difficulty, of course, is deciding where the line is to be drawn, and the boundary may change depending upon public opinion, medical advances, and the views of the medical profession as well as the current state of the law.

In a recent case from the Republic of Ireland a young girl suffered catastrophic mental damage during a minor operation, but she was not technically in a persistent vegetative state. After many years of total care in hospital her relatives wished her to be allowed to die. The doctors refused to cease care. Eventually, after detailed consideration, the court was prepared to grant an order for cessation of treatment.

The last issue to which I wish to draw attention is probably the most controversial; that is, euthanasia and physician-assisted suicide. Most legal systems try to draw a legal line or boundary beyond which the intervention or non-intervention of doctors will be categorised as illegal. In Scotland the present boundary has come to rest at the point which stops short of permitting active intervention by a doctor with the intention on humane grounds of bringing to an end the life of a patient. For example, giving a lethal injection with the intention of killing a patient is criminal. Switching off a respirator in the knowledge that the patient will die is not. Although it is possible to put forward both legal and moral arguments to justify the present position, some of the distinctions which are made are certainly narrow.

The physiological and legal debate should not be allowed to obscure the fact that many of the decisions which are made are in essence policy decisions. The legal boundaries have been and will be challenged in public debate, and through the democratic process as well. In practice, challenges will be made also by physicians, both overtly and covertly. It is the last such method which is the most dangerous as it is individualistic, secretive, and non-accountable. To those with religious views in the Christian and some other religious traditions, death by starvation over a period of weeks by stopping nutrition, or death after heroic efforts to find the correct drug dosage to inhibit pain, may be acceptable consequences of the present boundary. But for many individuals, their families and their physicians, this is unacceptable. The demand for humane death in circumstances chosen by the individual rather than death resulting from the disease process will continue to be made. Some physicians, as we have seen recently in the press, have put themselves at risk to meet that demand in secret for humane purposes. Recently Dr David Moor in England was tried for murder. It was reported that he talked openly about many of his patients whom he had said he had helped to die over 30 years. He was charged in connection with an 85-year-old patient who was reported to have been in agony with terminal cancer. After trial, the jury acquitted him, as you know.

A succession of surveys has shown that physicians are ready to help patients to die who have incurable diseases or who are in immense pain. In 1994 a survey in the British Medical Journal found that six in ten doctors had been asked by patients to hasten their death and that a third had complied with their request. Both the secret and the overt challenge by physicians have dangers and disadvantages. There is, I believe, no substitute for public and professional debate, and debate in Parliament about such fundamental issues leading to democratic change in the legislative framework. Consensus can be obtained. Such legislative consensus has all the disadvantages which legislation on morally complex issues always has. We have seen this, for example, in legislation relating to abortion and homosexuality.

Despite these disadvantages this is probably the best form which a democratic society has so far developed for laying down rules which require to operate in a diverse society. But will the legislative grasp this difficult issue both in relation to general policy and procedural framework and safeguards?

In the Netherlands, as I understand it, physician-assisted suicide is legal but subject to safeguards and procedures which have been laid down by law. In this country members of Parliament have been slow to debate and legislate in these difficult areas. As a result some of the decisions have been left to the courts

While recognising that the courts cannot provide an ideal solution to such problems, they are the only other forum which we have to resolve some of these difficult disputes and to give some legal guidance. It is, of course, essential to develop professional guidance and to promote ethical committees and internal forums to deal with disputes between relatives or disputes about treatment. There is little doubt that resorting to the court should be, and is, appropriate only in exceptional cases.

Physicians, as I see it at least, will always bear a heavy responsibility as individuals and as a professional group, but for their own protection and the protection of patients they should not be left to bear this responsibility alone. In some areas legislative change may be essential. In other areas general principles may be developed by the courts.

The profession itself should continue to be alert to develop and publish guidance and standards not only for the assistance of physicians themselves, but also to inform and allay the fears of relatives and patients and generally to inform public debate.

Thank you very much for listening to me.

REFERENCES

1 *Airedale National Health Service Trust* v *Bland* 1993 1 All England Reports 821 at 866.
2 *Re MB* 1997 28 Butterworths Medico Legal Reports 175.
3 *Re S* 1993 1 Family Law Reports 426.
4 *Re MB* 1997 2 Family Law Reports 426 at 440-1.
5 *Paton* v *British Pregnancy Service Trustees* 1979 Queen's Bench 276 at 279 *per* Sir George Baker, P.
6 *Attorney General's Reference* (No. 3 of 1994) 1997 3 All England Reports 936 at 945.
7 *St George's NHS Trust* v *S* 1998 3 Weekly Law Reports 936 at 953.
8 *Re C* 1994 1 All England Reports 819.
9 *Law Hospital NHS Trust* v *Lord Advocate* 1996 Session Cases 301.