

# The Autonomy of Others: Reflections on the Rise and Rise of Patient Choice in Contemporary Medical Law

Graeme Laurie

## Introduction

I had never met Ken Mason until I came to work with him. It was a terrifying prospect from afar but the reality was so completely different to what I had imagined. When I took up a position in the School of Law at the University of Edinburgh in 1995 Ken assured me that this would be his last year of teaching and research. He has said that every year since; and here we are, ten years on, still working together, and I have long since become infected with his irrepressible enthusiasm for medical law. To understand Ken Mason's contribution to the discipline, however, it is important to appreciate not only the impact of his training in medicine or the influence of his faith,<sup>1</sup> but also his unwaivering commitment to others. His dedication to his students at times knows no bounds; his sense of professional duty – medical and academic – is profound. If ever there was a team player it is Ken Mason. He is a self-confessed “communitarian” for whom, then, the rise and rise of the role of patient choice in the development of medical law over the course of its relatively short life<sup>2</sup> is something of an anathema.

I feel confident in saying this not only because of my decade-long relationship of working closely with him, but also because of the wealth of publications he has produced which stand as a testament to his views. Central among these is his seminal work with Sandy McCall-Smith, *Law and Medical Ethics*, which was first published in 1983 and which goes into its seventh edition in 2005; it will henceforth be known as Mason and McCall-Smith's *Law and Medical Ethics*. The partnership of Mason and McCall-Smith has represented a unique voice in medical law which has never doggedly adhered to the mantra of ‘patient autonomy’ in the course of the developments of the last 30 years or so. Rather, they have sought balance in responding to the – often overwhelming – range of issues which has washed up on their desks demanding attention. At times, that search for a balance has been between private and public interests – where, for example, should we place limits on patient autonomy in defence of broader community interests (whether these be about public health, allocation of resources or the sort of society in which we want to live)?; at other junctures the tension to be resolved has been between private interests – what, for example, of the autonomy of the patient face-à-face the autonomy of others, such as her parents, relatives or, even, her doctor?

This chapter explores Ken Mason's contributions to medical law by focussing on his writings and other musings in and around notions of personal autonomy. It takes its

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<sup>1</sup> ‘It is important that authors in this field show their colours and I think it only fair to readers to say that I am a practising Roman Catholic; but this does not mean that I can have no individual conscience. In any case, what I am trying to speak of is the ethical practice of medicine, not the application of religious precept’: Mason, J.K., *Human Life and Medical Practice*, Edinburgh, Edinburgh University Press, 1988, p.vii.

<sup>2</sup> When did medical law begin? Consider the work of the influential figures of Ian Kennedy, Andrew Grubb and Sheila McLean in the 1970s and 1980s, and in whose company we must also include Alexander McCall-Smith and Ken Mason himself; but other such figures, including Margaret Brazier and Derek Morgan, have pointed to the as-yet largely unexplored historical jurisprudence in various quarters of the medico-legal world.

structure from an event that was held in Edinburgh in 1998 to contemplate The Future of Medical Law and Ethics and at which Ken delivered the keynote address. In looking forward to where we were going he also looked back to where we had been: his family crest is of a dog marching along and looking over his shoulder and the motto is *Respicens Surgo* or 'Looking Backwards, I Go Forward'. This chapter, then, involves both a retrospective on cases which Mason has considered to be of crucial importance in the development of medical law, as well as a horizon-gazing exercise for the future which draws on my own work with Mason about the relative importance and impact of concepts of patient autonomy. I should stress, however, that what follows is a very personal interpretation of what my colleague and friend has had to say.

“The five most significant decisions in the United Kingdom over the past 30 years”

You can learn a lot from reading the preface of books. The preface to the fifth edition of *Law and Medical Ethics* reads:

One of us recently delivered a paper in which an attempt was made to choose, and justify the choice of, five most significant decisions in the United Kingdom over the past 30 years. The fact that the choice of *Re B*,<sup>3</sup> *Gillick v Norfolk and Wisbech Area Health Authority*,<sup>4</sup> *Re MB (adult: medical treatment)*,<sup>5</sup> *A-G's Reference (No. 3 of 1994)*<sup>6</sup> and *R v Cox*<sup>7</sup> would be unlikely to be that of any other interested observer goes simply to illustrate the enormous diversity of this academic field.

The paper referred to is Ken Mason's keynote address at the conference *The Future of Medical Law and Ethics* held in the School of Law at the University of Edinburgh on 31 October 1998. This paper has never been published. Yet, one of the great advantages of working with Ken Mason - beyond access to the man himself - is access to his extensive library, including his unpublished papers. This particular paper is tantalising in giving us a modicum of insight into his choice of these five cases over the many thousands of others that make up the discipline of medical law. Together with his extensive publications and my personal experiences of working with him, therefore, I think it is possible to use it as a platform to assess the sheer range and extent of influence that Ken Mason's contributions have had on medical law in the United Kingdom.

### *Re B*

It is perhaps ironic to begin a discussion of autonomy with a case which is ostensibly about the best interests of a person who - to all extents and purposes - has no autonomy. Much of the value of the case, however, lies in the question, whose autonomy is at stake?: a perennial issue for Mason.

*Re B* concerned a child with Down's syndrome who was also suffering from an intestinal obstruction that would prove fatal but for surgical intervention which, in the event, would be a relatively straightforward procedure. Notwithstanding, the parents felt that it would be unkind to subject their daughter to such an intervention and that it would be

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<sup>3</sup> [1981] 1 WLR 1421, [1990] 3 All ER 927.

<sup>4</sup> [1986] AC 112, [1985] 2 All ER 402, HL.

<sup>5</sup> [1997] 2 FCR 541, (1997) 38 BMLR 175, CA.

<sup>6</sup> [1998] AC 245, [1997] 3 All ER 936, HL.

<sup>7</sup> (1992) 12 BMLR 38.

best for her not to have the operation; the consequence would be the death of the child within a matter of days. She was made a ward of court in the face of the parents' refusal and moved to another hospital for the operation, but the surgeon charged with carrying it out refused to do so:

I decided...to respect the wishes of the parents and not to perform the operation, a decision which would, I believe (after 20 years in the medical profession), be taken by the great majority of surgeons faced with a similar situation.<sup>8</sup>

While other surgeons were found who were prepared to operate, the climate of the time shows how there was genuine ambivalence among the medical profession as to whether and how far parental choice should be respected.<sup>9</sup> The importance of the case lies in the fact that it established for the first time the parameters of the autonomy of parents faced with life and death decisions concerning their children. For Mason, however, the case also represents a watershed moment in establishing how the British courts would reconcile tensions between autonomous choices (albeit in the name of another) and the principle of respect for sanctity of life. In his 1988 work, *Human Life and Medical Practice*, for example, he asks poignantly: 'Can we honestly say that parents can and should decide that their child must die when there is no evidence that this is its preferred option?'<sup>10</sup>

This, in fact, also engages a further important perspective that Mason has long supported, namely, the incorporation of the perspective of the incapacitated person into the decision-making process in respect of their care. He has argued in various places for the adoption of an objective substituted judgment test as a preferred, more honest approach to the best interests test which prevails in the United Kingdom.<sup>11</sup> Unlike the normal operation of a substituted judgment test which seeks to take the actual prior views of a person into account - and so is of no utility if no such prior wishes exist (as in the case of neonates and the life-long incapax) - Mason's construct of an objective test asks what would this person want if they could express views on their circumstances, objectively assessed. In a further interesting twist, however, Mason sees this not only as promoting a less paternalistic version of patient autonomy but also as permitting a wider range of extraneous interests to enter the fray, for example, those of relatives, carers or even the state.<sup>12</sup> It is disingenuous to apply a best interests test which, it is claimed, considers all such other interests to be irrelevant yet which also ignores the realities of medical practice and the fact of overlapping and inter-connected interests.<sup>13</sup> Best interests also deprives the incapax of the opportunity to be altruistic or selfless - which in itself is

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<sup>8</sup> Re B, n 3 above [1981] WLR at 1423; [1990] All ER at 928.

<sup>9</sup> From the leading medical literature of the time we have this: '...in the absence of a clear code to which society adheres there is no justification for usurping parents' rights', see Editorial Comment, 'The Right to Live and the Right to Die' (1981) 283 *British Medical Journal* 569.

<sup>10</sup> *Human Life and Medical Practice*, n 1 above, p.65.

<sup>11</sup> See, for example, Mason, J.K., 'Master of the Balancers: Non-voluntary Therapy under the Mantle of Lord Donaldson' [1993] *Juridical Review* 115. In particular, see the rulings of Lord Donaldson in *Re J (a minor)(wardship: medical treatment)* [1990] 2 All ER 930, [1992] 6 BMLR 25 and *Re J (a minor)(medical treatment)* [1992] 4 All ER 614, [1993] Fam 15.

<sup>12</sup> We explore this further in Mason, J.K. and Laurie, G.T., *Mason and McCall-Smith's Law and Medical Ethics*, (7<sup>th</sup> Ed), Oxford, Oxford University Press, 2005, paras 16.130 - 16.138.

<sup>13</sup> Although see *Re T (a minor)(wardship: medical treatment)* [1997] 1 WLR 242, [1997] 1 All ER 906 in which the court did take into account the impact of requiring a child to undergo a liver transplant on the parents and their ability (and willingness) to care for that child subsequently. Here 'parental autonomy' - in the sense of determining the interest of the family unit and including the child's best interests - was upheld.

an interest, and one which we do recognise in other contexts, for example, when involving incapacitated persons in research.<sup>14</sup>

But even this conception of substituted judgment has its limits, as Mason acknowledges, and *Re B* is, indeed, a prime example of this. The court had no evidence whatsoever to determine the future quality of life of the child, and as Lord Templeman said:

[t]he evidence in this case only goes to show that if the operation takes place and is successful then the child may live the normal span of a mongoloid child with the handicaps and defects and life of a mongol child, and it is not for this court to say that life of that description ought to be extinguished'.<sup>15</sup>

There is a fundamental distinction to be drawn between physical and mental defects; while we, as potential proxy decision-makers, might be able to say how tolerable life might be having to live with physical pain and suffering, none of us who is privileged enough to be free of mental affliction knows what it is like to be a person with Down's Syndrome.<sup>16</sup> Faced with such uncertainty the Court of Appeal in *Re B* preferred to respect the sanctity of the life of the child; in doing so, however, it also established the defining parameters for future decisions in respect of life and death decisions surrounding the (non)-provision of medical treatment, namely, quality of life and intolerability. As Templeman LJ said:

There may be cases ... of severe proved damage where the future is so certain and where the life of the child is so bound to be full of pain and suffering that the court might be driven to a different conclusion.<sup>17</sup>

We shall return to the notion of intolerability and Mason's view of substituted judgment presently. For now, it is suffice to note that it is not a view that has (yet) been accepted by the British courts.<sup>18</sup> *Re B* proceeded on the basis of an application of the best interests test. It was an *ex tempore* judgment and as such extends to only a few pages; much of its impact therefore was left to be felt in the wake of the subsequent jurisprudence.<sup>19</sup> Notwithstanding, the judgment was clearly the gateway to a new era which positioned the notion of a patient's best interests – essentially a paternalistic stance – at the centre of disputes over the care of incapacitated patients.<sup>20</sup>

While this means that, in the main, the autonomy of the patient is either entirely excluded or resigned to a residual role, the autonomy of others is none the less further engaged, viz, who will decide those best interests? The subsequent jurisprudence reveals a very strong reluctance on the part of the courts to interfere with clinical autonomy when it comes to assessments as to the futility of beginning or continuing

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<sup>14</sup> See, for example, provisions in both the Mental Capacity Act 2005 and the Adults with Incapacity (Scotland) Act 2000 which permit incapacitated persons to take part in research subject to stringent safeguards.

<sup>15</sup> *Re B*, n 3 above, per Templeman LJ [1981] WLR at 1424; [1990] All ER at 929.

<sup>16</sup> See further Mason, J.K., *Medico-legal Aspects of Reproduction and Parenthood*, Aldershot, Gower Publishing Group, 1990, p.262.

<sup>17</sup> [1990] 3 All ER 927 at 929, [1981] 1 WLR 1421 at 1424.

<sup>18</sup> But see Lord Donaldson in the *Re J* cases, n 11 above, and our commentary in Mason and McCall-Smith's *Law and Medical Ethics*, n 12 above, paras 16.35 – 16.37, where he comes very close to applying a substituted judgment test.

<sup>19</sup> We discuss this in Mason and McCall-Smith's *Law and Medical Ethics*, n 12 above, chapter 16.

<sup>20</sup> The general principles were laid down in *Guardianship of Minors Act 1971*, s 1. See, now, *Children Act 1989*, s 1.

treatment. Indeed, the courts will not require practitioners to administer treatment against their better clinical judgment.<sup>21</sup> Matters may be different when the dynamics of a dispute are reversed, that is, when clinical judgment is in favour of care and the carers of the patient disagree.<sup>22</sup> Certainly, the courts have clarified that the best interests test refers to best overall interests and not merely best medical interests.<sup>23</sup> The advent of the Human Rights Act 1998 has done little to change the established orthodoxy; indeed, in the case of *Re Wyatt (a child)(medical treatment: parents' consent)* it was said that: '...in this case at least the Convention now adds nothing to domestic law'.<sup>24</sup> Although it has been confirmed that disputes over child care and treatment should be referred to the courts because of the need to respect the child's human rights,<sup>25</sup> it has also been confirmed, both domestically<sup>26</sup> and by the European Court of Human rights itself,<sup>27</sup> that an application of the best interests test by the medical profession on grounds of futility and which leads to the death of the child can be perfectly compatible with the Articles of the European Convention on Human Rights.

It seems, then, that the largely paternalistic approach of the best interests test remains ensconced in our law. It deserves such a label for two good reasons: (1) the essential framing of the construct places more focus on third party assessments of interests than on the autonomy of the patient, and (2) because it admits a significant role to the most paternalistic of all professions; a role which is no longer determinative but remains hugely influential. For those for whom paternalism remains a very dirty word, then, we might ask if matters could be balanced differently. It is here that we return to Mason's construct of the substituted judgment test. While he acknowledges that in most cases the outcome will be the same whether we apply best interests or substituted judgment, a recent example shows both the development of the law in this field and a perfect illustration of where Mason's model might make a real difference.

*W Healthcare NHS Trust v H and Another*<sup>28</sup> involved a patient who had been suffering from multiple sclerosis for 30 years, the last five of which involved artificial feeding and hydration and 24-hour care. She was barely conscience or sentient and when her feeding tube became displaced the question arose of whether it should be replaced. The first important point to note about the Court of Appeal decision is its reliance on the neonate ruling of *Re J*.<sup>29</sup> Mason and I have long-maintained that a continuum exists between withholding and withdrawal dilemmas from the beginning of life onwards, and this is the

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<sup>21</sup> See the *Re J* cases, n 11 above. Compare the first instance ruling in *R (on the application of Burke) v General Medical Council* [2005] 2 WLR 431, [2004] 3 FCR 579 and our associated commentary: Mason, J.K. and Laurie, G.T., 'Personal Autonomy and the Right to Treatment: A Note on *R (on the application of Burke) v General Medical Council*' (2005) 9 *Edinburgh Law Review* 123. But see now the devastating reversal of the decision by Court of Appeal on 28 July 2005, available at [2005] EWCA 1003.

<sup>22</sup> *Re T*, n 13 above.

<sup>23</sup> *Ibid.*

<sup>24</sup> *Re Wyatt (a child)(medical treatment: parents' consent)* [2004] Fam Law 866.

<sup>25</sup> *Glass v United Kingdom* [2004] 1 FLR 1019, (2004) 77 BMLR 120.

<sup>26</sup> *A NHS Trust v D* [2000] 2 FLR 677, (2000) 55 BMLR 19 (although it should be noted *en passant* that the facts of the case occurred a time before the Human Rights Act 1998 was in force).

<sup>27</sup> *Glass*, n 25 above. While the decision went against the United Kingdom in this case, this was primarily because the dispute had not been taken to court; the provisions of Article 8(2) ECHR could not, therefore, be relied upon. Notwithstanding, the ECtHR confirmed the acceptability of applying a best interests test.

<sup>28</sup> [2004] EWCA Civ 1324, [2005] 1 WLR 834.

<sup>29</sup> *Re J* [1990], n 11 above.

first explicit judicial acknowledgement of this as far as I know. It means, therefore, not only that best interests must apply in these cases, but also that intolerability becomes the watch-word as Lord Templeman suggested in *Re B*. Importantly, it also means that the court could not rely on the strong evidence from the family, who were opposing reinsertion of the feeding tube, that their relative would not want to be kept alive in such a state. From the best interests/intolerability perspective, however, Brooke LJ had this to say, bearing in mind that the patient was not wholly insensate:

The Court cannot in effect sanction the death by starvation of a patient who is not in a PVS state other than with their clear and informed consent or where their condition is so intolerable as to be beyond doubt...I cannot say that life-prolonging treatment...would provide no benefit...death by this route would...be even less dignified than the death which she will more probably face at some time in the more distant future.<sup>30</sup>

Mason's subjective judgment approach would elide this outcome, whether on a subjective or an objective basis, and may well pay more respect to the patient's residual autonomy as a result. Importantly, however, it would permit the views of the family to be taken into account in at least two senses: that they were saying that this woman would not want to be kept alive, and that this woman would doubtless not want to put her relatives through this experience.

Mason's choice of *Re B* as a seminal case has stood the test of time. It is one of those cases which has found application far beyond its original remit and which has triggered a whole new set of ethical and legal dilemmas. One such other case is Mason's second choice, *Gillick v Norfolk and Wisbech Area Health Authority*, and these are precisely the reasons why he chose it.

### *Gillick v Norfolk and Wisbech Area Health Authority*

*Gillick* arose from the publication of a seemingly-innocuous Department of Health memorandum of guidance authorising health care professionals to discuss family planning with minors without the explicit consent of their parents, albeit in restricted circumstances. Crucially, however, this extended to the provision of advice on contraception and even contraceptives themselves. Simply,<sup>31</sup> Mrs *Gillick* sought to have the instruction declared unlawful; the trial judge and Court of Appeal adopted polar opposite views with the Court of Appeal favouring the 'rights and duties' of parents. In the final analysis, and as Mason has frequently pointed out, more judges agreed with Mrs *Gillick* than disagreed with her, but the ultimate judgment fell to the House of Lords, and there the majority – 3:2 – disagreed with the appellant.

The seminal nature of *Gillick* stems from its attempt to respond to the realities and vagaries of human development – a complex process that is not amenable to the so-often-crude responses of law. As Lord Scarman stated:

If the law should impose upon the process of growing up fixed limits where nature knew only a continuous process, the price would be artificiality and a lack of realism in an area

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<sup>30</sup> *Ibid*, para 22.

<sup>31</sup> While other issues were engaged, such as the potential criminal liability of the health care professional, here we only consider the autonomy-related aspects of the case.

where the law must be sensitive to human development and social change.<sup>32</sup>

The law, of course, does exactly this by setting an arbitrary threshold for maturity based on numerical age and wholly divorced from subjective capabilities. The House of Lords in *Gillick* sought to establish a mechanism whereby more responsiveness to a child's particular circumstances could be shown; it did so not through the parents, however, but through the medical profession, as expressed in the oft-quoted speech of Lord Fraser:

[T]he doctor will, in my opinion, be justified in proceeding without the parents' consent or even knowledge provided he is satisfied on the following matters: (1) that the girl (although under 16 years of age) will understand his advice; (2) that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice; (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.<sup>33</sup>

The House of Lords made it abundantly clear that this was not *carte blanche* to the profession to ride rough-shod over the (residual) rights and responsibilities of parents and this remains embodied in professional guidance to this day.<sup>34</sup> The obvious question in the immediate aftermath of *Gillick* was 'what, precisely, are these (residual) rights and responsibilities?'. This was not, however, the primary preoccupation of most, whose attention, rather, turned to what the *Gillick* ruling meant for the autonomy of the child. Barely pausing for breath, the courts assumed that the precedent was not confined to its particular circumstances of contraception (and confidentiality<sup>35</sup>) but that it extended to the entire field of consent to medical treatment<sup>36</sup>: 'the term *Gillick-competent* is now part of medico-legal lore'.<sup>37</sup> Both issues – that of parental rights and that of child autonomy – converged in the cases of *Re R*<sup>38</sup> and *Re W*.<sup>39</sup> Each concerned minors of doubtful capacity, not for their immaturity *per se*, but because of mental disorders leading to questions about their ability to decide for themselves. In *Re R* a 15-year old girl displayed disturbing behaviour for which medication was required, yet she purported to refuse it during her more lucid periods. *Re W* concerned a 16-year old minor<sup>40</sup> suffering from anorexia nervosa who refused all care and endangered her life in doing so. In both cases the respective courts overrode the children's refusal and did so on the basis of best interests: a court has, through its wardship jurisdiction, the power to overlook any consent or refusal by a child if it is in her or his best interests to do so. As for the

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<sup>32</sup> [1985] 3 All ER 402 at 421.

<sup>33</sup> *Ibid* at 413.

<sup>34</sup> General Medical Council Confidentiality: Protecting and Providing Information (2004) para 28. See also General Medical Council Seeking Patients' Consent: The Ethical Considerations (1998) para 23.

<sup>35</sup> We discuss this in Mason and McCall-Smith's *Law and Medical Ethics*, n 12 above, paras 8.43 – 8.44.

<sup>36</sup> See, for example, *Re P (a minor)* [1986] 1 FLR 272, 80 LGR 301 (court agreed that a schoolgirl aged 15 should be allowed to have an abortion against the wishes of her parents. Butler-Sloss J said: 'I am satisfied she wants this abortion; she understands the implications of it').

<sup>37</sup> See, Mason and McCall-Smith's *Law and Medical Ethics*, n 12 above, para 10.27. This is a classic Mason aphorism.

<sup>38</sup> [1992] Fam 11, (1991) 7 BMLR 147.

<sup>39</sup> *Re W (a minor) (medical treatment)* [1992] 4 All ER 627, (1992) 9 BMLR 22. For a comparable Australian case, see *DoCS v Y* [1999] NSWSC 644.

<sup>40</sup> The statutory aspects of this under s.8 of the Family Reform Act 1969 are discussed in Mason and McCall-Smith's *Law and Medical Ethics*, n 12 above, paras 10.48 – 10.51.

residual nature of any parental rights, the courts confirmed that the change that had been brought about by Gillick was to remove any right to determine that a mature minor should be treated; there remained, however, a right to consent on the child's behalf, even in the face of the child's objection, provided, once again, that her or his best interests would be served in doing so.<sup>41</sup>

So where did this leave the autonomy of mature minors? On one view we might see *Re R* and *Re W* as aberrant cases, distinguishable from *Gillick*, because they concerned children of doubtful capacity and in such cases the general principle of best interests simply applies.<sup>42</sup> But this could not really hold water since there is no suggestion in the rulings that the 'right' of a parent or a court to consent is in any way dependent on the child's incapacity; it exists irrespective of mental capacity and, rather, by dint of immaturity per se. This was clearly confirmed in *Re L (medical treatment: Gillick competence)*<sup>43</sup> which concerned a critically-ill 14 year-old girl who professed the Jehovah's Witness faith and refused any treatment involving blood transfusions; treatment which was necessary to save her life. The dispute came to court and it ordered treatment against the child's refusal. Despite her maturity, she was adjudged not to be Gillick-competent on the basis that she had formed her views within the confines of her community and had not benefited from broader experience, and that she had not been informed of the likely horrific nature of her death, albeit that she understood that she would die as a direct consequence of her refusal.<sup>44</sup> Importantly, however, the court stated obiter that in the circumstances of her case treatment would have been ordered even if she had been Gillick-competent. So the matter seems fairly unequivocal: recognition of a minor's developing autonomy is conditional on treatment decisions being in her or his best interests – as the House of Lords intended – and the concern of their Lordships not to ride rough-shod over residual parental rights remains a core part of the law.

At the risk of continuing the Fox & Hounds metaphor too far, it is nevertheless apt to recall that Ian Kennedy famously said of *Re R* that it was 'driving a coach and horses through *Gillick*'.<sup>45</sup> And in *Re W* we also have Balcombe LJ acknowledging that '[i]n logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment'.<sup>46</sup> But logic is not the only issue, nor is autonomy the only value at stake. Mason has long argued in defence of a more protectionist stance towards the mature minor, particularly where decisions can have serious ramifications such as ongoing suffering or death. But is it a sustainable and defensible position? After years of long drawn-out debate – the subject is one of our favourite 'fights' in classes that we teach together – I rather think that it is; moreover, I think that there are parallels yet to be drawn with the law's attitude towards the adult incompetent that may assist Mason's

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<sup>41</sup> On the interesting concept of 'family autonomy', protected by the Irish Constitution no less, see, *North Western Health Board v W (H)* [2001] IESC 70. For commentary see Laurie, G.T., 'Better to Hesitate at the Threshold of Compulsion: PKU Testing and the Concept of Family Autonomy in Eire' (2002) 28 *Journal of Medical Ethics* 136.

<sup>42</sup> See, in fact, *Re R*, n 38 above.

<sup>43</sup> [1998] 2 FLR 810. [1998] 2 FLR 810, [1999] 2 FCR 524, [1998] Fam Law 591

<sup>44</sup> See too *Re E* where it was said of a 15-year-old 'Gillick competent' boy who was refusing blood transfusion: 'I respect this boy's profession of faith, but I cannot discount at least the possibility that he may in later years suffer some diminution in his convictions', per Ward J: *Re E (a minor)* [1993] 1 F.L.R. 386; [1994] 5 Med. L.R. 73.

<sup>45</sup> Kennedy, I., 'Consent to Treatment: The Capable Person' in Dyer, C (ed) *Doctors, Patients and the Law*, Oxford, Blackwell, 1992, chapter 3.

<sup>46</sup> *Re W (a minor)(medical treatment)* [1992] 4 All ER 627, at 643.



case.

Mason's starting premise is that truly autonomous choices require not only information but a level of understanding and appreciation of the consequences of each decision. As he has argued:

...while consent involves acceptance of an experienced view, refusal rejects that experience – and does so from a position of limited understanding. Furthermore, a refusal of medical treatment may close down the options – and this may be regretted later in that the chance to consent has now passed. The implications of refusal may, therefore, be more serious and, on these grounds refusal of treatment may require greater understanding than does acceptance. A level of comprehension sufficient to justify refusal of treatment certainly includes one to accept treatment but the reverse does not hold; the two conditions cannot be regarded as being on a par.<sup>47</sup>

An answer to this is to provide more and better information to facilitate understanding. This, surely, is the criticism to be levelled at the decision in *Re L* (above). In this sense, the mature minor's position is not that different from the adult *incapax* who is also held to a higher standard. As *Re C* (adult: refusal of medical treatment)<sup>48</sup> made very clear, a patient of dubious capacity must demonstrate actual understanding of the nature and consequences of their decision. Mere capacity to understand is not enough as it is for the *capax* adult, but then, the mature minor and the *incapax* adult do not fall into that category. Nor was the ruling in *Gillick* ever designed to catapult the minor into that category – this comes later when the crude numerical threshold is crossed. Only at that point do all of the attendant consequences of adulthood follow, one of which is the presumption of capacity. In this sense, then, the adult *incapax* is in a diametrically-opposite position to the mature minor for whom the default is a presumption of incapacity. Mason's argument is not that we should not seek to respect the emerging autonomy of children, but rather that we owe them continuing obligations to protect them from decisions that are manifestly bad for them. How do we know that they are bad? Because the parents or the carers or the courts tell us so. Such an overtly paternalistic view does not devalue autonomy as a relevant criterion but it does seek a more sophisticated accommodation of the values and interests at stake: when autonomy and welfare stand in direct opposition it is by no means clear that autonomy should be the trump card.<sup>49</sup>

In the same way that an incompetent adult is not incompetent in respect of all decisions because the presumption is one of competence, the corollary holds that a competent child is not necessarily competent in respect of all decisions because the presumption is one of incompetence. But in all cases where incompetence is in issue – either as a presumption or as a fact - the same welfare principles apply if we perceive the patient to be in harm's way. To an extent, however, the framing of the debate in terms of *Gillick*-competence is misleading because this language admits of the possibility that the presumption of

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<sup>47</sup> For a contrary clinico-legal view, see Devereux, J.A., Jones, D.P.H. and Dickenson, D.I., 'Can Children Withhold Consent to Treatment?' (1993) 306 *British Medical Journal* 1459.

<sup>48</sup> [1994] 1 All ER 819, [1994] 1 WLR 290.

<sup>49</sup> In the *Matter of X* [2002] JRC 202 the court respected the refusal of a 16-year-old woman to authorise transfer of tissue from her aborted fetus to the police to determine paternity for the purposes of possible prosecution of a man for unlawful sexual intercourse. This was so despite affidavits from the parents consenting to the procedure. None the less, the court reiterated that its inherent jurisdiction meant that the refusal could be overridden in the child's best interests; in the instance case, however, the court was not convinced that those interests would be served by dismissing the refusal.

incompetence can be rebutted and, for the child, that competence to decide can be demonstrated; the implication from this being that competent decisions – however bad – should be respected. But this is only a part of the considerations required under Lord Fraser’s test. No amount of evidence about capacity to decide autonomously can elide the responsibility also to consider whether such a decision is nonetheless in the child’s own best interests. Thus, as *Re L* (above) demonstrates, it is entirely possible to acknowledge that a state of competence has been reached and still to decide that manifestly bad decisions will not be respected. It is one of the few areas of medical law concerning ‘choice’ where autonomy does not have the last say. By the same token, it should not be thought that an autonomy perspective and a best interests perspective are necessarily mutually exclusive. The decisions in this field are replete with references to the need to accommodate the mature minor’s views as far as possible. Nor should it be thought that a best interest perspective necessarily means that a refusal of medical care is necessarily an unacceptable option. The case of *Re T*<sup>50</sup> demonstrates judicial sensitivity to the position of parents who did not want to put their child through painful surgical procedures even although there was overwhelming medical support for intervention and even although the refusal will mean that the child would die. All this was justified in the child’s own best interests.

Those who criticise the rulings typified by *Re R* and *Re W* seek to treat mature minor autonomy in the same crude sense that the law of majority does – once you reach an all-important threshold (be it age or Gillick-competence) then the presumption shifts and you are free to take all the bad decisions you want irrespective of their consequences. But being in a state of autonomy is not an all-or-nothing affair nor is it an irreversible state (unlike majority). There may be many times in life when we as adults do not have capacity to take our own decisions; not in an organic disease-related sense, but perhaps because of a lack of information or understanding or guidance from others. The presumption of capacity, however, masks this reality in all but the most clear-cut of cases which, then, usually are disease-related. No one is there to protect us from ourselves. In the context of the child, however, where there is a presumption of incapacity and where there is a continuing obligation to protect his or her welfare, such an all-or-nothing attitude to autonomous decision-making can be seen as tantamount to abandonment of the patient. While we may find this acceptable in the case of the competent adult, there are too many doubts and unresolved issues to justify the bringing forward of the ‘clear-line approach’ to maturity and autonomy. There is no such clear line.

*Re MB (adult: medical treatment) and A-G’s Reference (No. 3 of 1994)*

Perhaps the best (or worst?) examples of clear-line thinking in medical law relate to the so-called maternal/fetal conflict and to the question of the legal status of the fetus. These neatly come together in Mason’s choice of *Re MB (adult: medical treatment)* and *A-G’s Reference (No. 3 of 1994)* in his list of seminal cases and it makes sense, therefore, that they be considered together. The choice of these cases reflects the very strong interest, and influence, that Ken Mason has had in reproductive matters throughout the course of his ‘third’ career.<sup>51</sup>

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<sup>50</sup> *Re T (a minor)(wardship: medical treatment)* [1997] 1 WLR 242, [1997] 1 All ER 906.

<sup>51</sup> Prior to his position as an Honorary Fellow in the School of Law, Ken Mason was Regius Professor of Forensic Medicine in the University of Edinburgh and prior to that had a very distinguished career as a pathologist in the Royal Air Force.

Re MB confirmed that the ruling from the earlier decision in Re T (adult: refusal of medical treatment)<sup>52</sup> – that an adult patient of sound mind has an absolute right to consent to or to refuse medical treatment - applies equally to the pregnant woman even if her decisions might result in the death of her unborn child. Some doubts about the extension of the ‘absolute autonomy’ principle to the pregnant woman carrying a viable fetus had been expressed in Re T itself,<sup>53</sup> and the distinction was applied in a handful of extremely contentious cases,<sup>54</sup> but the Court of Appeal was categorical in Re MB; at least as to principle. In practice, however, the position has almost always been different and there is precious little evidence of cases in which a pregnant woman’s refusal has been accepted. The common scenario in the disputed cases, including Re MB,<sup>55</sup> is to impose a finding of incompetence thereby allowing the patient to be treated in her own best interests – the classic default position. For example, in Bolton Hospitals NHS Trust v O<sup>56</sup> the court wholeheartedly endorsed the Re MB principle but still found a woman with post traumatic stress temporarily incompetent due to panic induced by flash-backs. Furthermore, the assumption has always been that it is self-evidently in the woman’s best interests for the child to be born. Only in St George’s Healthcare NHS Trust v S, R v Collins, ex p S<sup>57</sup> did the Court of Appeal condemn an involuntary caesarean section which had been carried out under the authority of the mental health legislation. This was a trespass on an otherwise competent woman.

For Mason, the tenor of these precedents typifies the bluntness of the law as a tool for social change or for regulating ethical practice. His insights from the medical perspective are strongly cognisant of the challenges faced by medical staff and of the dilemma of being responsible, simultaneously, for two lives. The categorical ‘principled’ stand of the law which so clearly favours one of those lives does not alleviate the ethical dilemma, even if it makes the position on potential legal liability abundantly clear. It is no wonder that the law is ambivalent in practice because the practical realities are far more complex than dogged adherence to the principle of the law would suggest. Yet, it is questionable whether the law can ever be more responsive to the doctor’s dilemma of ‘two lives/one choice’ in light of the clear preference for, and privileging of, the principle of respect for personal autonomy over other values such as, for example, the principle of sanctity of life. But even if the debate were to be re-framed along autonomy lines – for example, the autonomy of the woman v. the (future) autonomy of the future person – it is still clear that any such conflict could not be resolved ‘...on autonomy grounds alone’.<sup>58</sup> And all of this ignores the fact that the two parties to the conflict are not of equal standing, at least in the eyes of the law. Indeed, it was a concern with the particular legal status of the fetus

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<sup>52</sup> [1992] 4 All ER 649, (1992) 9 BMLR 46.

<sup>53</sup> [1992] 4 All ER 649 at 652-653, (1992) 9 BMLR 46 at 50.

<sup>54</sup> See Re S (adult: refusal of medical treatment) [1992] 4 All ER 671, (1992) 9 BMLR 69 which was decided only two and a half months after Re T. See too, Norfolk and Norwich Healthcare (NHS) Trust v W [1996] 2 FLR 613, (1996) 34 BMLR 16, Rochdale Healthcare (NHS) Trust v C [1997] 1 FCR 274. and Tameside and Glossop Acute Services Trust v CH (a patient) [1996] 1 FLR 762, (1996) 31 BMLR 93. For analysis see Grubb, A ‘Commentary’ (1996) 4 Medical Law Review 193. The consequence in each case was the imposition of a caesarean section against the women’s express wishes.

<sup>55</sup> The woman in Re MB suffered from a phobia of needles which led her to refuse a caesarean operation while all the time stating that she wanted her baby. She was declared incompetent as a result; in the event, however, she consented to the procedure.

<sup>56</sup> [2003] 1 FLR 824, [2003] Fam Law 319.

<sup>57</sup> See, [1999] Fam 26, (1998) 44 BMLR 194.

<sup>58</sup> I borrow this expression from Ngwena, C. and Chadwick, R., ‘Genetic Diagnostic Information and the Duty of Confidentiality: Ethics and Law’ 1 Medical Law International 73.

that led Mason to add Attorney-General's Reference (No. 3 of 1994)<sup>59</sup> to his list.

Attorney-General's Reference (No. 3 of 1994) is the first of two criminal cases among Mason's top five. Its significance here lies in the on-going unwillingness of the law – or perhaps more accurately, the courts – to grasp the nettle on the definitive status of the fetus in law. While this is perhaps more understandable in the context of cases which involve a potential conflict between the interests or rights of the mother and those of her fetus (should we ever choose to recognise them), this was not a problem in the instant case. As Mason has commented: '...we are here concerned, not with fetal/maternal conflict, but, rather, with the protection of the fetal/maternal symbiosis'.<sup>60</sup>

Attorney-General's Reference (No. 3 of 1994) was concerned with the relatively straightforward question of whether it would be competent to charge a person with murder for the death of a fetus from injuries sustained in utero. The case involved a man who had stabbed his pregnant girlfriend and, in doing so, inadvertently also stabbed the fetus. The woman went into premature labour and the child was born alive but died 120 days later. The man was charged with the murder of the fetus. In yet another example of clear-line thinking, it is now common ground that an unborn child has interests protected by law in a number of areas,<sup>61</sup> but that none of these crystallises as a 'right' until the child is born alive, and in some cases, survives a requisite period of time.<sup>62</sup> Accordingly, there has never been a recognised crime of feticide.<sup>63</sup> The refusal to recognise the fetus as a bearer of rights in se stems back to the seventeenth century,<sup>64</sup> and Attorney General's Reference presented as a perfect opportunity to revisit the rule. In the end, however, the House of Lords did no such thing. Instead, they further obscured the status of the fetus by leaving it in a form of legal limbo-land as neither a 'person' nor a 'thing' but a 'unique organism' which is not merely a part of its mother but which also had no distinct legal personality. Of this ruling Mason has had this to say:

Could it not be that modern genetics, physiology, applied psychology and the rest must now cast serious doubt on the concept that the fetus has no distinct human personality? I suggest that the serious conceptual disagreements between the Court of Appeal and the House of Lords evidence in the Attorney-General's Reference under discussion indicate that the time has come for a thorough review of fetal status – at least from the point of view of the criminal law. It seems wholly illogical that there should be an offence of neonatal murder but not of feticide, and that it is safer by far, in both civil and criminal jurisdictions, to kill a fetus rather than to injure it.<sup>65</sup>

One wonders how much logical has to do with it. As was pointed out above in the context of the protection of mature minors, logic is not all that is at issue. Although the absence of maternal/fetal conflict in this case offered an opportunity to establish a

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<sup>59</sup> [1998] 1 Cr App R 91.

<sup>60</sup> Mason, J.K., 'A Lords' Eye View of Fetal Status' (1999) 3 *Edinburgh Law Review* 246, at 250.

<sup>61</sup> For example, in tort, for negligently-caused harm both under the Congenital Disabilities (Civil Liability) Act 1976, and at common law (*Burton v Islington Health Authority*, *De Martell v Merton and Sutton Health Authority* [1992] 3 All ER 833 and *Hamilton v Fife Health Board* 1993 SC 369).

<sup>62</sup> The Congenital Disabilities (Civil Liability) Act 1976 requires the child to live 48 hours before it can seek compensation under the Act for negligently inflicted injury in utero.

<sup>63</sup> Mason distinguishes feticide from the offence of child destruction under the Infant Life Preservation Act 1929 on the basis that, '[c]riminal abortion involves the procuring of a woman's miscarriage which only results in feticide consequentially', see 'A Lords' Eye View of Fetal Status', n 60 above, fn 9.

<sup>64</sup> Sir Edward Coke, *Institutes of the Law of England*, Pt III, Chap 7, at 50.

<sup>65</sup> N 60 above, at 249.

precedent that would not necessarily lead to (impossibly) difficult choices as between parties, it must have been at the fore-front of their Lordships' minds whether – in these circumstances – any shift from the threshold of 'birth' as the trigger for rights would inevitably lead to similar debates being rehearsed in the maternal/fetal context. I have considered elsewhere the long-standing ambivalence of the courts to take on board arguments about fetal 'human rights',<sup>66</sup> and Mason has commented more recently on the same phenomenon.<sup>67</sup> This may be an area where maintaining clear-line thinking – even if the thinking itself is far from clear – is the only acceptable judicial policy.

### *R v Cox*

The above comment on reluctance to recognise any form of fetal rights for fear of losing control of the field, is, essentially, a point about slippery slopes, and nowhere are such concerns more prevalent than in the field of euthanasia. Mason's final choice of a criminal prosecution of a doctor for the deliberate taking of a patient's life is apt in bringing together the three main branches of medical law – medicine, law and ethics – in a particularly acute form where the ultimate respect that might be paid to a patient's autonomy – respect for their choice to die – potentially conflicts with the 'autonomy' of the medical profession in respecting its primary guiding principle: First do no harm.

It will be recalled that Dr Cox, a consultant rheumatologist, was convicted of attempted murder after administering potassium chloride – which is entirely toxic to the human organism and has no therapeutic application – to his patient, Mrs Lillian Boyes, on her repeated request to be helped to die to release her from the excruciating pain of her rheumatoid arthritis.<sup>68</sup> Dr Cox was convicted because the jury had no real choice. The usual devices that are employed on behalf of the medical profession to avoid the charge of euthanistic practices were not available to Dr Cox. Mrs Boyes was not terminally ill and there was therefore no medical intervention keeping her alive that could be withdrawn. The agent administered to her had no analgesic effect, so it could not be argued that the 'real' intention was to relieve pain, and that death only came as an attendant consequence. Indeed, the facts pointed to the conclusion that death was the primary intention. And finally, since the criminal law universally treats motive as irrelevant, the jury was left with the crude question: did Dr Cox intend to kill his patient?<sup>69</sup> To which the answer was an unqualified 'yes'. The law in the United Kingdom is currently too intransigent or inflexible to accommodate subtle, but crucial, distinctions between cases which do depend on motive.<sup>70</sup> As Mason has said: '...Dr Cox was certainly not a murderer as the word is commonly interpreted'.<sup>71</sup>

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<sup>66</sup> For consideration of whether a human rights analysis might strengthen the legal position of the fetus, see Laurie, G.T., 'Medical Law and Human Rights: Passing the Parcel Back to the Profession?' in Boyle, A. et al (eds) *Human Rights and Scots Law: Comparative Perspectives on the Incorporation of the ECHR*, Oxford, Hart Publishing, 2002.

<sup>67</sup> Mason, J.K., 'What's In a Name? – The Vagaries of *Vo v France*' (2005) 17 *Child and Family Law Quarterly* 97.

<sup>68</sup> *R v Cox* (1992) 12 BMLR 38.

<sup>69</sup> *R v Cox* (1992) 12 BMLR 38 at 39.

<sup>70</sup> Contrast this with the position in Switzerland where the legality of an act to assist another in dying is all about motive. So long as the assistance is provided is a selfless act – that is it is not for a selfish motive – then no criminal liability will flow from a successful assisted suicide. For commentary, See Guillod, O. and Schmidt, A., 'Assisted Suicide under Swiss Law' 12(1) (2005) *European Journal of Health Law* 25.

<sup>71</sup> Mason and McCall-Smith's *Law and Medical Ethics*, n 12 above, para 17.28.

So should the law in this field be changed, and what would inform our answer to this question one way or the other? It is illuminating within the field of medical law in the United Kingdom to contrast the views of Mason with those of Emily Jackson,<sup>72</sup> because they each come to the discipline from very different perspectives.<sup>73</sup> In the present context, for example, Jackson has recently argued that the continuing prohibition on active euthanasia at the explicit request of a patient runs entirely contrary to the autonomy ethos that has gripped the discipline in recent years. In particular, Jackson is extremely skeptical of the standard position of the medical profession that the mantra 'First do no harm' justifies a blanket ban on physician-assisted or accomplished death.<sup>74</sup>

Mason has himself pointed to the obvious answer to involving physicians in active euthanasia, namely, using specialists in the care of the terminally ill.<sup>75</sup> But his concerns are far more deep-rooted and, as one would imagine, are not resolved by an appeal to autonomy alone. First, he is acutely sensitive to the position of responsible medical staff who are asked to comply with requests to die when '[s]tandard medical teaching remains that we should never willingly and deliberately shorten life'.<sup>76</sup> This may be anachronistic for Jackson, but Mason's perspective nevertheless accurately reflects the attitude of much of the profession whose professional autonomy is at stake within any legally-sanctioned euthanasia regime.<sup>77</sup> This brings us to another of Mason's concerns, viz, the necessity of a conscience clause in any such framework. Recent legislative proposals in the House of Lords have reflected this, and the second of two Bills proposed by Lord Joffe included not only a conscience clause but also an associated obligation for anyone purporting to rely on the clause to refer the patient to a colleague who is prepared to adhere to the patient's request.<sup>78</sup> It is interesting to speculate what Mason's response would be to the recommendations from the House of Lords Select Committee set up to consider the Bill. In one respect, the Committee takes a broad team-based approach to the issue of conscience, acknowledging that:

Conscientious objections could however arise not only from doctors but also from other health care professionals, including nurses and pharmacists....[and that any new Bill]... should seek to address such

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<sup>72</sup> Professor of Medical Law at Queen Mary College, University of London.

<sup>73</sup> Compare, for example, Mason, J.K., *Medico-Legal Aspects of Reproduction and Parenthood*, Second Edition, Aldershot, Dartmouth, 1998 and Jackson, E., *Regulating Reproduction*, Oxford, Hart Publishing, 2001.

<sup>74</sup> Jackson, E., 'Whose Death Is It Anyway? Euthanasia and the Medical Profession' (2004) *Current Legal Problems* 415.

<sup>75</sup> Mason, J.K., 'Death and Dying: One Step at a Time?' in McLean, S.A.M. (ed), *Death, Dying and the Law*, Oxford, Oxford University Press, 1996.

<sup>76</sup> See Mason and McCall-Smith's *Law and Medical Ethics*, n 12 above, para 17.105 and quote from the medical correspondent of *The Times* in n 196.

<sup>77</sup> Evidence led to the House of Lords Select Committee on Assisted the Assisted Dying for the Terminally Ill Bill suggested that '...the Bill, if it were to become law, might well be unworkable because of the conscientious objections of many of those who would be called upon to put it into practice.', see House of Lords Select Committee on Assisted the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill – First Report*, HL 86-I, 2005, para 113. The Report continues: 'We did not, it has to be said, receive indications from the authorities in other countries where legislation of this nature has been enacted that significant problems had been encountered in regard to conscientious objection by large numbers of doctors and nurses, though it is perhaps necessary to bear in mind that the composition of the medical and nursing professions in this country is rather different from that in, for example, Holland, where over 90% of doctors are of Dutch origin', *ibid*, para 114.

<sup>78</sup> Two Bills were proposed in 2003 and 2004 respectively; the latter being the *Assisted Dying for the Terminally Ill Bill*.

situations as that in which, for example, a nurse with conscientious objections is asked by a patient to raise with a doctor on his or her behalf a request for assisted suicide or voluntary euthanasia.

And I imagine that this would be entirely in keeping with Mason's own perspective.<sup>79</sup> But the Select Committee also recommends that the obligation to refer the patient should be removed because, '[an]...obligation to refer a requesting patient to a colleague could nonetheless be regarded as an infringement of conscience'.<sup>80</sup> I suspect that this would jar with Mason as coming close to patient abandonment in a time of need. However much he might disagree with the request, he would probably consider it part of a professional's on-going commitment to the patient to facilitate their autonomous choices where the law is set up to see those choices through. The limit here would be on professional autonomy.

Perhaps contrary to what one might expect from Mason's medical training and religious faith, he is not entirely against assisting people to die; rather, his contribution to the debate has focused on the lack of clarity in what we mean by 'euthanasia' (only some forms of which he will endorse); it has drawn attention to the hypocrisy of the law in adhering to non-distinctions such as the act/omission distinction; and it has called for a more honest approach to what the medical professions are asked to do when the direct result of their actions is the death of their patients. All of this distils to the question of how acceptable forms of euthanasia may be brought within the fold of legally acceptable practice. Of course, what is 'acceptable' is highly subjective, but for Mason this is found in two sets of circumstances: the patient suffering from Persistent Vegetative State (PVS) and Physician-Assisted Suicide (PAS). Mason stops short, however, of endorsing active euthanasia in circumstances such as those in which Dr Cox found himself, largely on the grounds of concerns about slippery slopes, informed by the experiences of the Netherlands.<sup>81</sup> Indeed, he endorses an experiential and incremental approach to the legalisation of euthanistic practices.<sup>82</sup>

It is at this point that Mason and I part company. I am not convinced that any slippery slopes that might be deduced from the practice of euthanasia in one (or more) countries (and this itself is a disputed matter) necessarily prevents us from adopting a principled approach to euthanasia – an approach which is a logical extension of the principle of respect for personal autonomy. Nor do I see the impact on patient autonomy of disrespecting requests for assistance in dying as comparable to the impact on professional autonomy of respecting such requests. The disparity is simply too great not to prefer the former over the latter. But, then, this paper is not about me.

The role of legislation in this field is integral to Mason's approach. We have argued elsewhere in the context of the PVS patient that to rely on the fallacy of 'futility' to justify the withdrawal or withholding of artificial feeding and hydration from such a patient is fundamentally dishonest in that it obscures the reality that we have taken a quality of life decision that this person should die. No amount of semantics can avoid this, yet the continued reliance on this reasoning leaves the courts with only one option: to authorise the starvation of patients to death. This cannot now be changed save through statute and

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<sup>79</sup> See, for example, in the context of abortion, Mason's comments on *R v Salford Health Authority, ex parte Janaway* [1998] 2 WLR 442, CA; sub nom *Janaway v Salford Area Health Authority* [1989] AC 537, HL in *Medico-legal Aspects of Reproduction and Parenthood*, n 16 above, pp.127-129.

<sup>80</sup> Select Committee Report, n 77 above, para 32.

<sup>81</sup> See, Mason and McCall-Smith's *Law and Medical Ethics*, n 12 above, paras 17.16 – 17.23 and paras 17.120 – 17.124.

<sup>82</sup> Mason, J.K. and Mulligan, D., 'Euthanasia by Stages' (1996) 347 *The Lancet* 810.

we have advocated that this should be so.<sup>83</sup> In the context of Physician-Assisted Suicide Mason has proposed a number of reforming measures,<sup>84</sup> including this simple amendment to the Suicide Act 1961:

The provisions of s 2(1) shall not apply to a registered medical practitioner who, given the existence of a competent directive, is providing assistance to a patient who is suffering from a progressive and irremediable condition and who is prevented, or will be prevented, by physical disability from ending his or her own life without assistance.

In the final analysis, however, and as is stated above, Mason would not go so far as to condone, let alone legalise, what Dr Cox did for Lillian Boyes. In fact, his concerns may be summed up best if I rephrase this slightly: He would not condone nor legalise what Dr Cox did to Lillian Boyes. And, this, perhaps, is where the heart of the concern lies – the prospect of the medical professional taking on the mantle of the Bringer of Death is too much for a medical man whose conscience, and whose commitment to others, cannot allow autonomy arguments to triumph – however logical they may be.

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<sup>83</sup> See, Mason, J.K. and Laurie, G.T., 'The Management of the Persistent Vegetative State in the British Isles' [1996] *Juridical Review* 263 and for problems with the current statutory provisions, see Laurie, G.T. and Mason, J.K., 'Negative Treatment of Vulnerable Patients: Euthanasia by any Other Name?' [2000] *Juridical Review* 159.

<sup>84</sup> See, for example, 'Euthanasia by Stages', n 82 above, and Myers, D.W. and Mason, J.K., 'Physician Assisted Suicide: A Second View from Mid-Atlantic' (1999) 28 *Anglo-American Law Review* 265.