

Lecture Notes 2010-2011. Code: Med 10.01-v2B-03.11

Medical Law

Topic 10 (of 10): Death & dying.

Lecture 1 (of 2):

A Philosophical, Medical and Legal Aspect of Death:

Precisely When Does A Person Die?

Aim:

To provide an outline of the difficulties of defining death and the time of death; of the practical necessity for doing so.

Objectives:

After careful study of this topic you should be able to:

1. Explain the difficulty in defining precisely when a person dies;
2. Evaluate the merit of enacting a statutory definition of 'death';
3. Discuss whether a patient in the PVS is, or should be declared, dead.

"Diagnosis" & Certification of Death

In *Legal Aspects of Nursing*, **Dimond** states that: 'Certification of death is a medical task'. *Prima facie*, this would appear to be a straightforward task in light of a statement made by **Mason and McCall Smith** in the third edition of their book *Law and Medical Ethics* that:

"In practice, it is astonishing how often the moment of 'death' is perfectly clear. One can tell to the second when a loved one or a carefully observed patient dies; it is easy to understand the religious concept of the soul leaving the body."

However, this simplistic concept of death hadn't survived to the fourth edition where the authors had modified their statements [repeated in the 5th edn., 1999, p327, and then modified them again in **Mason & Laurie**, *Mason & McCall Smith's Law and Medical Ethics*, 8th edn., 2011, p464] to:

"... it is astonishing how often the moment of 'death of the person' is perfectly clear. It is generally possible to tell immediately when a loved one or a carefully observed patient 'dies'. In everyday terms, the patient has 'breathed his or her last' and his heart stops beating; this is 'somatic' death. But ... the individual cells of the body are not dead; depending on their specialised needs or characteristics, they will continue

to function until their residual oxygen is exhausted. Thus, the assumption that a person whose cardiorespiratory system has failed is dead is open to question, and this conundrum lies at the heart of the current philosophical conflict as to the meaning of 'dead' – the counter-argument to the 'stopped breathing' definition being that you cannot say that a body is dead when many of the bodily functions which contribute to the 'integrative function' of the body are still operating'.

The reason for inserting the word 'death' between inverted commas is at least an indication that "confirmation" of death is not always correctly diagnosed - because the moment of death is far from perfectly clear - as events in 1996 and 1997 have shown (when a couple of patients 'recovered' after being diagnosed as being 'dead') - even if a practical recognition of it is, generally, 'perfectly clear.'

Mason and Laurie (2011, p521) note contrasting concepts of death in giving a 'layman's' definition from *Chambers Twentieth Century Dictionary* as "the state of being dead; extinction or cessation of life." This suggests that death of the whole body is a uniform event, i.e., an event which takes place at a particular time. However, they then include the definition from *Steadmans Medical Dictionary* which notes that: "in multicellular organisms death is a gradual process at the cellular level with tissues varying in their ability to withstand deprivation of oxygen." This indicates that death occurs when the tissues most resistant to oxygen deprivation finally succumb; i.e. that death is a 'process,' 'a permanent state of tissue anoxia'. A crucial issue to be determined, then, lies in the definition of 'permanence'. Failure to determine permanence confuses death with dying or temporary cessation of cardio-respiratory activity.

The 'permanence' of a 'sudden death' resulting from (say) a 'coronary attack' may be challenged by way of electrical stimulation or cardiac massage, coupled, perhaps, with artificial respiration or ventilation. Nevertheless, even if a patient is, apparently, 'saved from the dead' it is likely that some cellular death has occurred by virtue of the temporary failure of oxygen distribution. This raises an issue of central ethical and legal importance in that as ...

"the cells of the brain are outstandingly the most sensitive to oxygen deprivation and, moreover, they are irreplaceable. Thus, a situation may arise whereby the body as a whole is brought back to life but where it is now controlled by a brain which is damaged to an uncertain degree. The decision to restore an interrupted cardiac function is not, therefore, a simple choice between the good (life) and the bad (death). It imposes the serious and urgent problems independent of the diagnosis of death ... which ... lead us to believe that, on practical grounds alone, a period of some 15 minutes of cardiorespiratory failure should be regarded as permanent." (per **Mason & Laurie**, 8th edn., 2011, p522).

The significance of the '15 minutes of cardiorespiratory failure' should now be seen in the context of *Lim v Camden Islington Health Authority* [1979] QB 196, where a female hospital

patient had suffered irreversible brain damage when 25 minutes had elapsed from cardiac arrest to the restoration of normal breathing, **Lord Denning** said she was brought back to 'a life which is not worth living'. He noted the agonizing decision that had to be made by the medical professionals involved when he asked:

“is she to be kept alive? or is she to be allowed to die? Is the thread of life to be maintained to the utmost reach of science? or should it be let fall and nature take its inevitable course? When is it appropriate to say: ‘For mercy’s sake, let the end come now?’”

[**N.B.:** Prior to 1993, it was thought that to refrain from continuing action necessary to preserve the life of a patient who is not ‘brain dead,’ but who would never recover consciousness, i.e. to withdraw ‘futile’ treatment with the inevitable consequence of the patient’s death, would be regarded as an example of *passive*, if not *active*, euthanasia. That even when it was known that the patient would have voluntarily consented to this, it would not be permissible for a doctor in this country to withdraw the treatment: it would be regarded as murder if it resulted in the patient’s death. However, the House of Lords, in Airedale NHS Trust v. Bland decided that such withdrawal was not murder. The decision was based on the finding that it was not in Bland’s best interests that his life should be prolonged by the continuance of futile medical treatment or care. The impact of this case is discussed *infra*].

‘Death defined in terms of ‘brain death’.

The traditional definition of death was based on cessation of breathing and cessation of heartbeat: cardio-respiratory failure implied death of a patient as a whole. However:

“the heart depends for its own tissue oxygen on the lungs which, in turn, are useless without the distributive function of the heart. Together they supply oxygen to the brain which ... cannot function in the absence of component heart and lungs - yet the lungs, themselves, depend on a functioning brain stem. ... the only segment of this triad which cannot be substituted is the brain. There are, therefore, *strong logical arguments for defining death in terms of brain death* rather than in the generally accepted terms of cardio-respiratory failure; indeed, Pallis taught that all death is, and always has been, brain stem death and that circulatory arrest just happens to be the commonest way to bring such death about. [Ultimately] we must turn to the brain when the natural functional condition of the lungs - or, occasionally, of the heart - is obscured by the intervention of a machine.”

(*per Mason & Laurie*, 8th edn., 2011, p524).

Of the three main areas of the brain, the cortex, the thalamus and the brain stem, it is the brain stem which is least affected by oxygen deprivation. Thus, if the brain stem is damaged by hypoxia (oxygen deprivation) then it is virtually certain that the rest of the brain is at least as damaged, if not more so. The significance of ‘brain stem death’ is, perhaps, appreciated when it is realised that on the death of the cortex the patient is already in the ‘persistent vegetative state’ *per Jennet*, whereas, according to **Mason & Laurie**, if the brain was functioning normally, ‘the only unnatural ways in which [brain stem death] can

reasonably be expected in the presence of a normal cerebrum are accidents involving the cervical spine, judicial hanging or beheading' (!) {see p.525, 8th edn., 2011}.

By definition, then, the *irreversibility* of brain stem death does not include coma subject to *reversible* causes such as those resulting from drug overdose, hypothermia and metabolic disorders. However, 'brain stem death' is merely at the basis for determining the death of a person/human being [**not** necessarily synonymous terms], i.e. death is determined by *medical criteria* (e.g. by way of electroencephalograms and/or angiograms): there is no statutory definition of death in English law.

Is Certification, and/or Declaration, of 'Death' Always Properly Based on a 'Medical Decision?' Precisely When Does A Person Die?

As noted (on p1), certification is a medical task in that a death certificate must be issued by a registered medical practitioner because, *inter alia*, the cause of death must be stated: ***Births and Deaths Registration Act 1953***. Of the other two questions addressed here, the answer to the 2nd question - is death always properly based on a medical decision - is an emphatic 'no': declaration of death is based on a medical decision in so far as the decision "delineates the clinical indicators of the death of a human being, in accordance with which death is to be declared" (*per Gervais* (1986)). However, clarification of the meaning of the concept of human death is a *philosophical task*; medical practitioners do not have the *unique* competence to make this a medical decision.

With regard to the third question - precisely when does a person die - many definitional issues have to be addressed, e.g.: is death an event or a process? Is there a distinction between 'human being' and 'person' or are they synonymous? Is death based on a biological or a philosophical concept? If the former, does the body have to putrefy before it can be declared dead? If the latter, should a person in the persistent vegetative state (pvs), e.g., someone such as Tony Bland, be declared dead?

Brain Stem Death, Causation and the Significance of 'time of death'.

Until relatively recently, if an assailant was to be convicted of murdering his victim, the victim must have died within a year and a day of the wrongful act. [**N.B.:** This rule has now been abolished following review by the ***Law Commission*** in ***The Year and a day Rule in Homicide, Consultation Paper 136 (1994)***. See the ***Law Reform (Year and a Day Rule) Act 1996, c.19***]. In 1981, however, under the old rule, it fell to be decided that if a victim was being maintained on a life support machine [i.e., a ventilator] would a doctor who 'switched it off' break the chain of causation between the assailant's attack and the victim's death? That he wouldn't and that a "proper medical treatment consequent upon illness or injury

plays no part in legal causation,” meaning that conviction for murder could stand, was decided in: R v Malcherek and Steel (1981):

R v Malcherek and Steel [1981] 2 All ER 422

Here, the Court of Appeal dealt with two cases. In the first, the defendant had stabbed his wife. In the second, the defendant had attacked a girl, causing her multiple skull fractures and severe brain damage. Both victims were put on life support machines which were then disconnected *when brain-stem death was diagnosed*. Both defendants were found guilty of murder on the basis of their acts being *continuing, operating and substantial* causes of the deaths of their victims. **Lord Lane CJ** said:

“.. it is ... somewhat bizarre to suggest ... that where a doctor tries his conscientious best to save the life of a patient brought to hospital in extremis, skilfully using sophisticated methods, drugs and machinery to do so, but fails in his attempt and therefore discontinues treatment, he can be said to have caused the death of the patient ... Where a medical practitioner, using generally acceptable methods, came to the conclusion that the patient was *for all practical purposes* dead, ... [then discontinuation of] treatment ... did not break the chain of causation between the initial injury and the death.”

Thus the removal of a patient from a life support machine in such circumstances is the removal of a person already certified as being dead. The ‘time of death’ arrived before removal of the support, and ‘the time at which the necessary tests [we]re undertaken [was] as likely to [have been] based on the criterion of convenience as on anything else.’ Accordingly, the specification of a ‘time of death’ is *most unlikely* to be precise. [cf. comments of **Mason & McCall Smith** on pl].

Post-Malcherek & Steel Development

In addition to medical practitioners being able to declare, in appropriate circumstances, that a patient is, *for all practical purposes*, dead, the courts have jurisdiction to declare a patient ‘dead’ for all legal and medical purposes.

Re A [1992] 3 Med LR 303

When a baby boy, ‘A’, was taken into hospital, the doctors who examined him could detect no heartbeat (‘day 1’). He was transferred to a different hospital the next day (‘day 2’). He was finally declared brain-stem dead on ‘day 5’. On ‘day 6’ second opinions reached the same conclusions: ‘A’ was brain-stem dead.

Held : (‘day 11’) **Johnson J**:

I have no hesitation at all in holding that A has been dead since [‘day 5’ – the day he was first declared brain-stem dead].

...

... I hold that I have jurisdiction to make a declaration that A is now dead for all legal, as well as medical, purposes, and also to make a declaration that should [any hospital consultant] consider it appropriate to disconnect A from the ventilator, in doing so they would not be acting contrary to the law.

Comment

A declaration of death for all legal, as well as medical, purposes is certainly death *for all practical purposes*. If death *for all practical purposes* is another way of expressing death for all legal, as well as medical, purposes, then we have had a consistent English common law definition of death for over 25 years. It is a matter of opinion whether death *for all practical purposes* is sufficiently explicit to be synonymous with death 'for all legal, as well as medical, purposes'.

What is the status of a PVS patient: dead or alive?

Airedale NHS Trust v. Bland [1993] 1 All ER 821

More than 90 people were killed at the Hillsborough Football Stadium tragedy in April 1989. However, one person, Tony Bland, did not suffer cardio-respiratory death or brain-stem death: he lapsed into the pvs where he remained for the next three and a half years until an application for the declaration that the *Airedale NHS Trust* might lawfully withdraw the medical treatment (feeding and hydration) that was sustaining him. Evidence was given that part of his upper brain had liquefied: there was no doubting that he would never regain consciousness; his capacity for personal identity was lost. An issue raised by the Counsel for the Official Solicitor was that withdrawing such life-support mechanisms would constitute murder: the *mens rea* - intention to bring about a person's death - was present and, it was contended, that the discontinuance of the regime of artificial feeding would constitute a positive act of commission - the *actus reus*. **Lord Browne-Wilkinson** addressed the omission/commission debate stating:

“ ... the criminal law draws a distinction between the commission of a positive act which causes death and the omission to do an act which would have prevented death. In general an omission to prevent death is not an *actus reus* and cannot give rise to murder. But where the accused was under a duty to the deceased to do the act which he omitted to do, such omission can constitute the *actus reus* of homicide, either murder (*R v. Gibbins* (1918)) or manslaughter (*R v. Stone* (1977)).”

However, he concluded that withdrawal of the nasogastric tube would not be the commission of a positive act. He said:

“ ... failure to continue to do what you have previously done is not, in any ordinary sense, to do anything positive: on the contrary it is by definition an omission to do what you have previously done.”

Lord Goff explained what was meant by PVS before stating his opinion. He said:

“[The] distinguishing characteristics of [PVS] are that the brain stem remains alive and functioning while the cortex of the brain loses its function and activity. Thus the PVS patient continues to breathe unaided and his digestion continues to function. But, although his eyes are open, he cannot see. He cannot hear. Although capable of reflex movement, particularly in response to painful stimuli, the patient is incapable of voluntary movement and can feel no pain. He cannot taste or smell. He cannot speak or communicate in any way. He has no cognitive function and can thus feel no emotion, whether pleasure or distress. The absence of cerebral function is not a matter of surmise; it can be scientifically demonstrated. The space which the brain should occupy is full of watery fluid.”

He continued by stating that:

“The central issue in the present case has been aptly stated by Sir Thomas Bingham MR to be whether artificial feeding and antibiotic drugs may lawfully be withheld from an insensate patient with no hope of recovery when it is known that if that is done the patient will shortly thereafter die. ...

“I start with the simple fact that, *in law*, Anthony is still alive ...

“[However] The doctor caring for a patient [such as Anthony] cannot ... be under an absolute obligation to prolong his life by any means available to him, regardless of the quality of the patient’s life. ... As I see it, the doctor’s decision whether or not to take any such step must ... be made in the best interests of the patient ...

“ ... the question is *not* whether it is in the best interests of the patient that he should die. ***The question is whether it is in the best interests¹ of the patient that his life should be prolonged by the continuance of this form of medical treatment or care.***

“ ... for my part I cannot see that medical treatment is appropriate or requisite simply to prolong a patient’s life when such treatment has no therapeutic purpose of any kind, as where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition. ... ***it is the futility of the treatment which justifies its termination.*** ...

¹ An incompetent patient’s best interests may now be determined under *s.4 Mental Capacity Act 2005*.

“There is overwhelming evidence that, in the medical profession, artificial feeding is regarded as a form of medical treatment; and even if it is not strictly medical treatment, it must form part of the medical care of the patient. ... in the case of discontinuance of artificial feeding it can be said that the patient will as a result starve to death; [but] the outward symptoms of dying in such a way, which might otherwise cause distress to the nurses who care for him or to members of his family who visit him, can be suppressed by means of sedatives.”

Thus, **Lord Goff** dismissed the appeal against the lawfulness of the declarations. In reading other judgments in this case, and commentaries on it, bear in mind:

1. The appropriateness, or otherwise, of classifying artificial feeding and hydration as medical treatment;
2. Exactly who the ‘treatment’ is futile for: the patient; the patient’s carers; and/or the patient’s family?
3. If there is no logical or moral difference between killing and allowing to die, why do we persist with the distinction in criminal law?
4. How is the Bolam test (a test developed in negligence) appropriate for determining the *legality* of a patient’s best interests ‘in a field dominated by the criminal law?’ (per **Lord Mustill**).
5. According to **Lord Browne-Wilkinson** in *Bland*, once a doctor believes that it is not in a patient’s best interests to continue with treatment then he (the doctor) is under a duty to withdraw it. That is: “Unless the doctor has reached the affirmative conclusion that it is in the patient’s best interest to continue the invasive care, *such care must cease.*”
6. Precisely when does ‘sanctity of life’ become subordinate to ‘quality of life?’
7. Are the courts the correct forum in which such cases should be heard; and should the judiciary develop the law or should it be left to Parliament?

(See also:

- (i) *Frenchay Healthcare NHS Trust v. S* [1994] 2 All ER 403;
- (ii) *Re D (Medical Treatment)* [1998] FLR 411;
- (iii) *Re H (A Patient)* [1998] 2 FLR 36;
- (iv) *Re G (Persistent Vegetative State)* [1995] 2 FCR 46; and
- (v) Practice Note on medical and welfare decisions for adults who lack capacity [2001] Family Law 551).

Should There Be a Statutory Definition of Death?

Notwithstanding the difficulties in specifying a time of death, a patient’s property cannot be disposed of by way of a will until death is certified. A will is ambulatory in nature; i.e. it only has legal effect on the patient’s death. Furthermore, a death certificate and arrangements for the disposal of the body can be confirmed only on the patient’s death; and the donation and transplantation of tissue under the **Human Tissue Act 2004** is dependent on a cadaver.

An important point which then arises is: if statutory provisions control the *removal* of (say) an organ from a *cadaver* for transplantation; shouldn't there also be a statutory definition of death? At present, death is based on *medical criteria*; transplantation of cadaveric organs is governed by *statute*. The change in the criteria for determining death [i.e. from cardio-respiratory to brain stem death] led **Brazier** to pose the question:

“Why should persons who until recently have always been regarded as alive, albeit dying, now be regarded at the same point of time as dead, simply because there is a national need for the use of such organs for transplantation?”

A perceived advantage would be the elimination of potential criminal and/or civil proceedings for the termination of treatment and/or the removal of organs from a patient not falling within a statutory definition of death. At present, should such an issue be a matter for litigation it has to be decided by a judge and jury in relation to criminal matters and for a judge alone in civil cases. **Brazier** concludes that: “Statutory guidance is preferable.”

The counter-arguments include that of potential inflexibility in that a rigid definition might not keep abreast of medical advances and it might need Parliamentary approval to revise or repeal an ‘outdated’ definition.

Skegg published *The Case for a Statutory Definition of Death* in 1976, and there has been legislation on the issue in both America and Australia. In America the **United States Uniform Determination of Death Act 1980** specifies that:

‘An individual who has sustained either:

1. Irreversible cessation of circulatory and respiratory functions, or
2. Irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.’

In Australia, legislation includes the **Human Tissue Act 1982** which specifies that:

‘A person has died when there has occurred:

- a. Irreversible cessation of the circulation of the blood in the body of the person, or
- b. Irreversible cessation of all functions of the brain of the person.’

However, as **Mason & McCall Smith** point out, while ‘most statutes, either existing or proposed apply some form of dual criteria of proof of death’ (8th edn., p532), they have an inherent weakness in that they ‘make no distinction as to *when* the alternative criteria are

to be applied.’ They conclude that there is no convincing need for a statutory definition of death since ‘in essence, all these measures do is to legalise good medical practice ...’

A final point in relation to medical practice is a caveat issued by **Brazier** who says:

“... however, it must be appreciated that without proper safeguards, medical changes in the definition of death could conceal policy decisions to introduce limited forms of euthanasia. At present, comatose patients, whether breathing spontaneously or on a life support machine, who have no hope whatsoever of regaining consciousness - frequently described as ‘human vegetables’ - are still regarded as living because, although irreversible brain damage has occurred, some activity of the brain is retained; they are not brain dead in accordance with current medical definitions.”

Certification of Cause of Death

If a doctor attended a patient during his (the patient’s) last illness, then the ***Births and Deaths Registration Act 1953*** imposes an obligation on the doctor to issue a *Medical Certificate of Cause of Death*: (the ‘death certificate’). However, this obligation is only imposed if the doctor was ‘in attendance during the last illness;’ the last visit was no more than 14 days before the patient’s death; and the mode of death was one which reasonably could be expected to arise from the illness for which the doctor was attending. If one of the three requirements is missing, the coroner has to be informed by the doctor and/or the Registrar of Births and Deaths. The issue of a certificate does *not* preclude a doctor from informing the coroner of the *suspected* cause of death, the exact cause being left for an autopsy. As ***Knight*** (p103 *Legal Aspects of Medical Practice*) stated, and as noted above, confirming ‘death’ may not be a straightforward matter as it is now ‘more a matter of definitions and ethics than a straightforward medical decision.’

However, that certification of a person’s ‘death’ can be premature and lead to an action in negligence following the successful resuscitation of the “corpse,” there is no doubt. At least two cases were under consideration for pursuing legal action following the incorrect (and negligent?) certification by GP’s of the ‘death’ of their patients in their own homes early in 1996.

When death is established correctly, a ‘death certificate’ is issued to the informant, the person responsible for notifying the Registrar of Births and Deaths, and the informant must take the certificate to the Registrar within five days of issue. On receipt of the ‘death certificate’ the Registrar registers the death and issues a certificate for disposal of the body.

References

Brazier & Cave *Medicine, Patients and the Law*, 4th edn., 2007. London: Penguin, Chs. 17, 19 (pp469-477) and 20;

Mason & Laurie, *Mason & McCall Smith's Law and Medical Ethics*, 8th edn., 2011. Oxford: OUP, Ch. 16.

Stauch, Wheat and Tingle, *Text, Cases & Materials on Medical Law*, 3rd edn., 2006. London: Routledge-Cavendish, pp633-641; 645-646; & 675-687.

Potential Examination Questions

1. To what extent, if at all, would English law benefit from having a statutory definition of death?
2. Critically evaluate the contribution to contemporary medical law of the House of Lords decision in Airedale NHS Trust v. Bland [1993] AC 789.