Legal issues concerning the withholding of feeding from patients

The law surrounding the withholding or withdrawal of feeding from patients is complex and dependent upon case law (also known as common law or judge-made law). There are no statutory provisions and the leading case in this area is the Tony Bland case (Airedale NHS Trust v Bland, 1993).

In 2003 parliament considered the Patient (Assisted Dying) Bill that would have legalised euthanasia, provided specified procedures were followed and specified forms completed. It also considered the Patient Protection Bill that would have made it a criminal offence to withhold treatment with the intention of causing the death of a patient. Neither bill completed all stages in parliament.

However, a new Assisted Dying for the Terminally Ill Bill was introduced into parliament on 8 January 2004. If enacted it would legalise euthanasia.

Withholding of feeding will be discussed through a selection of scenarios illustrating the kinds of problem that can arise in this difficult area of law. It is evident that whenever such difficult decisions have to be made, team working, communication with relatives, and sensitivity towards the patient’s condition are essential (Lennard-Jones, 1998).

The common law requires that health professionals act in accordance with reasonable professional practice (see the Bolam test in Box 1) and failure to communicate appropriately can itself be evidence of negligence.

**Withholding food in the best interests of the mentally incapacitated patient**

**Scenario 1: Dysphagia and nil by mouth**

Martha Brown is experiencing dysphagia (difficulty swallowing) and has been examined by a speech therapist who has advised that she should have no diet or fluids orally (nil by mouth) because of the danger of choking and inhalation. However, Ms Brown – who is not mentally capable of making her own decisions – is desperate for a cup of tea. The speech therapist’s advice is not accepted by the doctors, nurses or relatives, all of whom wish to take the risk and satisfy Ms Brown’s cravings by letting her drink a cup of tea. What is the law?

Ms Brown lacks the mental competence to make her own decisions and this means that decisions have to be made in her best interests. This was the ruling of the House of Lords in the case of F v West Berkshire Health Authority (1989). In that case the House of Lords declared that it was lawful for professionals to act in the best interests of a woman with severe learning disabilities by sterilising her.

When acting in her best interests the health professionals should act according to the Bolam test (Bolam v Friern Barnet HMC, 1957) of reasonable professional practice.

Applying these principles to Ms Brown’s case, it could be argued that she cannot make her own decision as to whether she should accept the risk of choking as a result of drinking. Health professionals therefore have to act in her best interests. Ascertaining the dangers of her choking would require a risk assessment of the likelihood of harm weighed against the benefits to her of drinking by mouth.

The speech therapist has clearly undertaken that assessment and concluded that the risks are too great. This risk assessment should involve an analysis of what would be the reasonable standard of care in such circumstances. It should consider any relevant research or guidelines – from the National Institute for Clinical Excellence, for example – or recommendations from professional bodies. If in the light of such information the health professionals and relatives allow Ms Brown to take liquids by mouth and she dies, then it could be argued that they had failed to take reasonable care of her and were in breach of their duty of care.

If it is considered to be in Ms Brown’s best interests not to take drinks by mouth, then adequate supervision must be put in place to prevent her drinking from taps or taking fluids from other patients.

**Scenario 2: Dysphagia and artificial feeding**

After considerable discussion by all health professionals and relatives it is agreed that the speech therapist’s advice should be followed and Ms Brown should be nil by mouth. The question then arises as to whether artificial feeding should commence. Ms Brown is incapable of giving consent and there is a dispute over this. The health professionals do not wish to commence artificial feeding, but the relatives want Ms Brown to receive it. What is the law?

The same principles of law have to be applied in deciding whether artificial feeding should commence for Ms Brown. She is incapable of making her own decisions and the health professionals therefore have a duty to act in her best interests. Relatives have a right to give their views, but they do not have the power to make the decision. The crucial question is what treatment is in Ms Brown’s best interests?

Professional views on her current clinical situation, prognosis, and quality of life should be considered when determining whether it is in Ms Brown’s best interests to...
start artificial feeding.

For example, if Ms Brown were in the terminal stages of cancer, with perhaps only a few days to live, then it would probably not be in her best interests for artificial feeding to commence. On the other hand, if she had suffered a stroke and rehabilitative treatment was in place to recover some of her lost functions, then artificial feeding would probably be appropriate. In this case Form 4 (for adults unable to consent to treatment) of the Department of Health’s Good Practice in Consent Implementation Guide (DoH, 2001) could be completed.

The determination of best interests needs to take into account the length of time that Ms Brown would have to receive artificial feeding and whether there are adverse risks to her from this intervention.

**Human rights** Could it be argued that any decision to withhold artificial feeding is contrary to article 2 of the European Convention on Human Rights 1951?

Article 2 states: ‘Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.’

In several cases it has been held that where it is in the best interests of a patient that he or she be allowed to die, then this is not a violation of article 2 and the right to life. For example, in two cases in October 2000, the family division of the High Court held that the withdrawal of life-sustaining medical treatment from a patient in a persistent vegetative state was not contrary to article 2 of the convention and the right to life. One case involved Mrs M, 49, who experienced brain damage during an operation abroad in 1997 and was diagnosed as being in a persistent vegetative state (PVS) in October 1998 (NHS Trust A v M; NHS Trust B v H, 2001).

The other case concerned Mrs H, 36, who fell ill in America as a result of pancreatitis at Christmas 1999 (NHS Trust A v M; NHS Trust B v H, 2001).

This distinction between letting a patient die when the best interests of the patient do not require further medical interventions, and killing the patient (which could constitute the criminal offence of murder, manslaughter or aiding a suicide) when action is taken to end the life of the patient, was highlighted in the case of Diane Pretty (R (On the application of Pretty) v DPP, 2001) who had motor neurone disease.

In her case, the House of Lords and the European Court of Human Rights in Strasbourg held that the Suicide Act 1961 (which made it a criminal offence to aid and abet another person’s suicide) was not incompatible with the articles of the European Convention on Human Rights 1951. Therefore, it would have been a criminal offence for Ms Pretty’s husband to help her die – an offence for which he could not be given an advance pardon. However, Ms Pretty could refuse any life-saving treatment and doctors would have had to accept her refusal.

**Scenario 3: Dysphagia and a living will**

Ms Brown has prepared a living will, which states that in the event of her suffering from motor neurone disease she would not wish to be given artificial feeding, artificial ventilation or any similar life-preserving treatment, but should be allowed to die. However, she would not refuse direct oral nutrition and hydration. The health professionals want the living will to be respected but the relatives believe it should be torn up and ignored. What is the law?

If a patient who is mentally incapacitated and unable to make her decisions has previously drawn up a living will setting out what treatments she or he would not wish to have in specified circumstances, then that advance directive or refusal would be binding upon health professionals.

There is no statute covering the situation. However, the House of Lords stated in the Tony Bland case that had Mr Bland drawn up a living will declaring that he wished to refuse artificial feeding in the event of his being in a persistent vegetative state, then that would have been binding upon health professionals (Airedale NHS Trust v Bland, 1993).

In its 1995 report the Law Commission (1995) recommended that living wills should be put on a statutory basis but its Mental Incapacity Bill including such provision has not been enacted.

However, the common law recognises a living will as lawful and that it enables people, when competent, to determine what treatment they would not want to receive at a time when they lack the competence to decide. In the scenario above, the health professionals would be entitled to withhold feeding to Ms Brown on the basis of her living will.

The relatives would have no right to insist that Ms Brown is given artificial feeding contrary to the living will. If the health professionals were uncertain as to the validity of the living will then an application could be made to the court for a declaration on the validity of the document and steps could be taken to keep Ms Brown alive until such time as the court made its declaration.

**REFERENCES**

- Airedale NHS Trust v Bland [1993] 1 All ER 821.
- Bolam v Friern Barnet HMC [1957] 1 WLR 582.
- F v West Berkshire Health Authority [1989] 2 All ER 545.
such a hearing were to be held, the official solicitor would represent the incompetent person.

**Scenario 4: A competent patient**

Angela Morgan is suffering from motor neurone disease and says that she does not wish to be given artificial feeding, artificial ventilation or any similar life-preserving treatment but should be allowed to die. She also refuses direct oral nutrition and hydration. Her competence to make these decisions is doubted. The health professionals wish to continue to treat her and overrule her refusals, and her relatives hold the same view. What is the law?

The first question to be decided is whether Ms Morgan has the mental capacity to make her own decisions. If she does possess the necessary capacity, then she must be allowed to refuse any treatments, even though they are life saving.

The Court of Appeal laid down a test for mental capacity in the case of MB(re) (Adult: Medical Treatment) (1997).

A person lacks the capacity (to give a valid consent) if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or refuse treatment. That inability to make a decision will occur when:

- The patient is unable to comprehend and retain the information that is material to the decision, especially as to the likely consequences of having or not having the treatment in question;
- The patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision.

In the case of MB(re) (Adult: Medical Treatment) (1997), a pregnant woman was suffering from a phobia of needles and was therefore held to be mentally incapacitated concerning her ability to make a decision about having a caesarean section (since needles and injections are clearly an integral element of the procedure). The operation was carried out in her best interests.

In contrast to this is the case of B(re) (Consent to Treatment: Capacity), 2002, a patient who was paralysed following a haemorrhage in her neck. This patient succeeded in her application for artificial ventilation to be withdrawn.

Two psychiatrists examined her and agreed that she was mentally competent. She was awarded a nominal amount as a trespass to the person occurred when she was placed on the ventilator contrary to her wishes.

If the test recommended in MB(re) (Adult: Medical Treatment) (1997) is applied to Ms Morgan and she is found to be mentally competent, then it is her legal right to refuse any treatment, even if it is life saving.

**The future** It is unfortunate that despite recommendations dating back to 1995 there has been no statutory provision in the area of withholding feeding, except in Scotland where the Adults with Incapacity Scotland Act 2000 is in force.

A white paper was issued by the Lord Chancellor’s Office in 1999 setting out the government’s proposals for statutory provision. However, there was no provision in the Queen’s Speech in November 2003 for legislation in the current parliamentary session.

In the absence of statutory provisions, the white paper commended the British Medical Association’s guidance on advance statements (BMA, 1995).

The BMA has also provided advice on withdrawing treatments (BMA, 2000) as has the Royal College of Paediatrics and Child Health with its Withholding or Withdrawing Life Saving Treatment in Children: A Framework for Practice (1997).

Draft legislation to bring the white paper proposals into force was published in June last year and was the subject of scrutiny by a joint committee of the House of Commons and the House of Lords.

The joint committee published its report in November 2003 and made almost 100 recommendations on changes to the draft bill including the change of title from the Mental Incapacity Bill to the Mental Capacity Bill. The introduction of a revised Mental Capacity Bill into parliament is awaited at the time of writing.

The progress through parliament of the Assisted Dying for the Terminally Ill Bill 2004 will be watched with considerable concern and interest. If enacted it would have huge repercussions for the topics considered in this article.

**BOX 1.** USING THE BOLAM TEST

The traditional way of determining the standard of care in relation to an action for negligence is to apply the Bolam test. This is drawn from a legal case (Bolam v Friern Hospital Management Committee, 1957) in which the judge said: ‘The standard of care expected is the standard of the ordinary skilled man exercising and professing to have special skill.’

In order to establish what would be the reasonable standard of care in individual cases, expert evidence is provided to the court. Reforms of civil procedure have made it clear that the experts owe a duty to the court and that, where possible, both sides should agree on a particular expert or experts.

The opinion of the expert would be based on current research on clinically effective practice and on current thinking as shown in approved texts.