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Position statement:

Withdrawing or withholding of nutrition and/or hydration

1. Withdrawal or withholding of nutrition and/or hydration when death is imminent can be considered

The SCHB accepts that the withdrawal or withholding of nutrition and/or hydration in a dying patient whose death is both imminent and inevitable can be considered as good medical practice if the burden of the intervention outweighs its benefit and the intention is to relieve suffering rather than to hasten death.

2. Nutrition and hydration are part of basic medical care

The benefit of receiving nutrition and hydration cannot be assimilated to a treatment since they are the essential elements required to stay alive. Thus, nutrition and hydration should be given to all patients, except in the last stages of a terminal illness if the burden of the intervention outweighs its benefit and the intention is to relieve suffering rather than to hasten death.

3. Withdrawal or withholding of nutrition and/or hydration when death is not imminent should not take place

It has been suggested that the withdrawal or withholding of nutrition and/or hydration would be in best interest of persons who are considered to have no prospect of recovery, such as in PVS, and that it is fundamentally different from any positive action taken with the purpose of ending patients' lives.

In response to this, the SCHB notes that:

It would be unethical to withhold or withdraw medical treatments, nutrition or hydration, howsoever administered, from any person with the intention of causing the death of or causing harm to that person.

Indeed, it can never be in the 'best interests' of a person who is not dying to undertake an intervention which would result in his or her death.

Furthermore, any medical intervention (including nursing and/or palliative care) which offers a reasonable hope of benefit to the person without any undue burdens should be provided.

The SCHB notes that there is a fundamental difference between making health care decisions and making value-of-life decisions. Physicians are not qualified to make value-of-life decisions or to decide which life is worthwhile and which is not. Physicians may determine whether an intervention in the health field is futile and valueless, but they can never determine whether a life is futile or valueless.

4. Withdrawal or withholding of nutrition and/or hydration could lead to euthanasia

The SCHB concurs that if a patient is not dying and a health care professional intentionally withdraws or withholds nutrition and hydration from him or her, then this could be considered as euthanasia. In this regard, the right to life under the European Convention on Human Rights could be violated.

Because killing by starvation or dehydration may be described as cruel, painful and unpleasant, it might lead to requests for euthanasia by other means such as lethal injections. Indeed, if the withdrawal or withholding of nutrition and/or hydration did become acceptable medical practice, then those advocating euthanasia may eventually campaign for lethal injections as a more humane approach than death by starvation.

5. Physicians should not be afraid to give artificial nutrition and hydration

There is a risk that some health professionals may be reluctant to begin artificial nutrition and hydration in the mistaken belief that, once initiated, it cannot be withdrawn. This could result in some patients failing to receive nutrition and hydration for their own benefit. The best interest of the patient should be re-evaluated regularly.

Position Paper on: The withdrawing or withholding of nutrition and/or hydration

1. Definitions and general information

Intervention in the health field: Any intentional activity, withholding of activity or the withdrawal of activity in the health field. Interventions include:

Medical treatment: Any positive intentional activity designed to address a specific physical or mental disorder in the best interests of the person. Artificial nutrition and hydration are not generally recognised as treatments (however, since the Bland case (1993) in England and Wales artificial feeding can be considered, in law, as a form of treatment).

Extraordinary treatment: Any treatment which:

holds no reasonable hope of benefit;

would place disproportionate burdens on the patient in relation to likely benefit; or

is too expensive for the healthcare service in relation to its possible benefit.

Basic care: Any positive healthcare activity which is part of the fundamental needs of a person and does not specifically address a physical or mental disorder. Advance directives do not generally include basic care, which is considered as always being necessary in order to provide humane assistance.

(The General Medical Council accepts that there is no legal or commonly accepted definition of basic care nor of what is covered by this term. In the medical profession it is most often used to refer to procedures or medications which are solely or primarily aimed at providing comfort to a patient or alleviating that person's pain, symptoms or distress. It includes the offer of oral nutrition and hydration. Indeed, a distinction is generally made between 'artificial' and 'oral' nutrition and hydration where food or drink is given by mouth, the latter being regarded as part of basic care [1]. Others, however, disagree with this distinction.)

Best interests: The highest level of well-being that is achievable for a specific person. Best interests include medical benefit, respect for the wishes and beliefs of the patient including his or her spiritual and religious beliefs.

Benefit: The clinical advantage or the net gain that a person may receive through a particular intervention. Since the Bland case (1993) in England and Wales, benefit has included non-clinical benefit and may encompass the very existence of a person (being alive).

Persistent vegetative state (PVS): a condition resulting from brain damage, characterised by a lack of consciousness, thought and feeling although reflex activities, such as breathing, continue.

Artificial hydration: The provision of solutions of salts and glucose by artificial means in order to overcome a pathology in the swallowing mechanisms. The solutions may be given parenterally as a temporary measure to prevent fluid depletion until a naso-gastric tube is inserted. As the sole treatment over weeks their use is associated with progressive under-nutrition and eventually death.

Artificial nutrition: The provision of nutritious fluids containing balanced proportions of fat, carbohydrate, protein, vitamins and trace elements by artificial means in order to overcome a pathology in the eating mechanisms. It can be given through a naso-gastric tube or intravenously. Intravenous feeding requires considerable clinical skill and organisation since it is liable to major complications, particularly blood-borne infection. It is reserved for patients with intestinal failure [2].

Artificial ventilation: The provision of mechanical ventilation (generally accompanied by the need for circulatory support) when a patient's spontaneous ventilation is not adequate to sustain life. It is regularly used in critically ill patients to gain control of their ventilation and as prophylaxis for impending collapse of other physiologic functions. If artificial ventilation is subsequently found to be futile it is usually withdrawn on the basis of a patient's best interests. This is because the clinical benefits no longer exceed the burdens and the patient's imminent death is inevitable. The purpose of commencing intensive life support methods including mechanical ventilation is not to prolong life indefinitely where there is no prospect of recovery. Instead its primary aim should be to support the critically ill individual while they return to health. Hence the withdrawal of intensive life support may be appropriate if recovery is not possible. The intention in withdrawing life-support is not to bring death, but rather to withdraw futile treatment, although it is possible to foresee that death may occur as a result of this action. In the few cases where the person is not dying but is dependent on mechanical ventilation, the situation could be similar to artificial hydration and nutrition.

2. Principles and purpose

Some health care professionals regard the provision of artificial nutrition and hydration as basic care which should always be provided unless the patient's imminent death is inevitable, in which case the benefits may no longer be proportional to the burdens [3].

Others make a distinction between the insertion of a feeding tube - which is classed as treatment - and the provision of nutrition and hydration through the tube, which is considered as basic care [4]. From this perspective, decisions not to insert a feeding tube, or not to reinsert it if it becomes dislodged, would be legitimate medical decisions whereas a decision to stop providing nutrition and hydration through an existing tube would not.

In addition, the legal and moral equivalence of withholding and withdrawing treatment was expressed by Lord Goff and Lord Lowry in the Bland case, with the latter saying:

> *"I do not believe that there is a valid distinction between the omission to treat a patient and the abandonment of treatment which has been commenced, since to recognise such a distinction could quite illogically confer on a doctor who had refrained from treatment an immunity which did not benefit a doctor who had embarked on treatment in order to see whether it might help the patient and had abandoned the treatment when it was seen not to do so" [5].*

3. History

To be developed

4. England and Wales - Legislation, Case Law

4.1. Developments

In 1989, Tony Bland a 17 year-old football fan, was left in a persistent vegetative state (PVS) following the Hillsborough stadium disaster. He was able to breathe, metabolise food and excrete waste without advanced medical assistance. The only help he needed was artificial feeding through a tube into his stomach [6]. In 1993, Mr. Bland's carers obtained permission from the House of Lords to stop this feeding process [7]. However, not all basic care was withdrawn and the nurses looking after Tony Bland continued their work until death occurred about 10 days later [8].

Whether artificial nutrition and hydration constitutes medical treatment or basic care was one of the central questions considered by the House of Lords in the Bland case [9]. The view of three of the five Law Lords who considered this case was expressed by Lord Goff as follows [10]:

> *"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".*

This classification of artificial nutrition and hydration as medical treatment, though not generally accepted, has however been adopted in other subsequent cases in England and Wales [11] and is now established common law. Moreover, artificial nutrition and hydration can now be withdrawn from mentally incapable patients if physicians deem it to be in their best interest.

Some confusion has arisen, however, from the fact that the guidance issued by the Courts following the Bland judgement specifically referred to patients in PVS without making reference to other serious conditions in which a decision to withhold or withdraw artificial nutrition and hydration might arise. Thus, for some conditions, such as advanced dementia or very severe strokes, a legal vacuum exists though a practice has developed where, in some cases, a decision is made that life-prolonging treatment, including artificial nutrition and hydration, would not be a benefit to the patient and should not be provided or continued.

Artificial nutrition and hydration have been considered as medical treatments by the British Medical Association (BMA) since 1992. Furthermore, in June 1999, the BMA ethics committee proposed that the withdrawal of artificial nutrition or hydration from incompetent patients should not just be possible for patients in PVS but should also be an option for individuals who have suffered a 'serious stroke or have severe dementia' [12]. In addition, the BMA does not believe that these cases should be routinely subject to court review but that standard policies and guidance should be established outlining the criteria and steps to be followed in reaching these decisions. Such guidelines would then help to ensure that proper and transparent procedures are followed [13].

The Law Commission has also reiterated the need for additional safeguards for the withdrawal of artificial nutrition and hydration in its report on Mental Incapacity [14] and decided that alternatives to a Court declaration in each case should be considered.

In a briefing for the UK parliamentary delegation in the Council of Europe in 2004, the UK government indicated that it felt that the withholding or withdrawal of medical treatment that has no curative or beneficial effect should not be confused with the act of deliberately killing a patient. An adult with capacity is able to refuse any form of medical treatment. Where the patient is incapacitated and has not made a relevant advance refusal of treatment, treatment will be lawful if it is in the best interest of the patient. Hence, if the treatment is not in the best interest of the patient it will not be lawful to initiate or to continue that treatment. In line with good practice, decisions to withdraw medical treatment should be made only after discussions with the healthcare team and, wherever possible, those close to the patient.

Leslie Burke Case

In July 2004, a High Court judge ruled in favour of a case brought by Leslie Burke that *"If life-prolonging treatment is providing some benefit it should be provided unless the patient's life, if thus prolonged, would from the patient's point of view, be intolerable"*. If there remains any doubt in the matter, the judgement added, it should be *"resolved in favour of life"*. Moreover, if patients have not made a "living will" of their preferences for treatment and are unable to express an opinion because of their illness, doctors must presume that treatment should be given and then apply the *'intolerability'* test [15].

The judge went on to indicate that with respect to the European Convention on Human Rights *"...The personal autonomy which is protected by Article 8 embraces such matters as how one chooses to pass the closing days and moments of one's life and how one manages one's death. ... The dignity interests protected by the Convention include, under Article 8, the preservation of mental stability and, under Article 3, the right to die with dignity and the right to be protected from treatment, or from a lack of treatment, which will result in one dying in avoidably distressing circumstances. ... Important as the sanctity of life is, it has to take second place to personal autonomy; and it may have to take second place to human dignity."* [16]

Following this, however, the General Medical Council reversed the ruling in the Court of Appeal in July 2005 by arguing that physicians could be put in an impossible position since artificial nutrition is classed as a form of treatment by the GMC. Doctors would have had to provide treatment which they knew would be of no benefit or could even be harmful.

The Court of Appeal also made it clear that doctors must already honour the wishes of competent patients who wish to be kept alive: *"no authority lends the slightest countenance to the suggestion that the duty on the doctors to take reasonable steps to keep the patient alive ... may not persist. Indeed it seems to us that for a doctor deliberately to interrupt life-prolonging treatment in the face of a competent patient's expressed wish to be kept alive, with the intention of thereby terminating the patient's life, would leave the doctor with no answer to a charge of murder."* [17]

Another consequence of the Court of Appeal's judgement was its effective abolition of the test of 'intolerability'. This previous test meant that in deciding whether treatment should be withdrawn in cases where there has been no specific request for life-sustaining treatment, there is a strong presumption in favour of the continuation of life. The presumption can be displaced, but only if it can be demonstrated that continued life would be intolerable. But the Court of Appeal modified this by indicating that *"The test of whether it is in the best interests of the patient to provide or continue [Artificial Nutrition and Hydration] must depend on the particular circumstances."* However, 'circumstances' are much more elastic test than 'intolerability' and commentators suggest that the new test will be much more difficult to police [18].

4.2. Present situation

Competent adults have the right to refuse any intervention in the health field, even if that refusal results in their death [19]. The patient is not obliged to justify his or her decision but the health team will usually wish to discuss the refusal with the patient in order to ensure that he or she has based that decision on accurate information and to correct any misunderstandings.

Moreover, since the ruling made after the case of Tony Bland in 1993 [20] which established that treatments conferring no benefit on a patient, including artificial nutrition and hydration, may be stopped, a Court may now declare that it is lawful to withdraw medical assistance considered to be of *no net benefit* to the patient. Thus, since this judgements and other similar cases, the provision of artificial nutrition and hydration of adults can now be considered as a medical treatment and no longer just part of basic care.

But though the House of Lords classified artificial nutrition and hydration as treatment, it conceded that their withdrawal was a particularly sensitive matter. Thus, for the protection of patients and doctors and for the reassurance of the patients' families and the public, it was decided that additional safeguards should be put in place. The House of Lords recommended, therefore, that for the time being in all cases where the withdrawal of artificial nutrition and hydration was being considered from a patient in PVS, a Court declaration should be sought in order to determine the best interests of the individual. Accordingly, the clear advice from the English Courts is that a declaration should be sought for each case in which it is proposed to withdraw artificial nutrition and hydration from a patient in PVS or a condition closely resembling PVS. (Since the current guidance states that the patient must have been in the condition for at least six months before a diagnosis of PVS can be confirmed, the question of *withholding* artificial nutrition and hydration from patients in this condition does not arise.)

However, the withdrawal of artificial nutrition and hydration from a patient who is in PVS without a Court declaration may be lawful. Indeed the guidance issued by the General Medical Council relating to the withdrawal of artificial nutrition and hydration does not place an obligation on a doctor to seek the court's approval before withdrawing such support [21]. But it would, at present, leave the doctor open to criticism, and potentially legal challenge, for failing to follow established procedures and guidelines [22].

The General Medical Council further indicated that a decision to withhold or withdraw feeding or hydration may only be made

after a full assessment of the patient's requirements and the possible means of providing nutrition and hydration; after a full consultation with the healthcare team and those close to the patient (although under current law, while relatives should be consulted, doctors have the ultimate say [23]); and a second opinion from a senior clinician who is not already directly involved in the patient's care [24].

In each case of patients in PVS that the law has considered, it has decided that it would not be unlawful to withdraw artificial nutrition and hydration, on the basis that its provision was not in the best interests of the individual patient [25],[26]. But existing guidance from the Courts on the withdrawal of artificial nutrition and hydration refers only to patients in PVS and United Kingdom Courts have not yet considered other cases. Clearly this situation may change over time. Doctors should, however, be aware that until the Courts have specifically considered non PVS cases, their discretion to make decisions to withdraw artificial nutrition and hydration in these circumstances could be challenged [27].

Additional Case Law:

There is no obligation to give treatment that is futile and burdensome [28].

For children or adults who lack capacity to decide, in reaching a view on whether a particular treatment would be more burdensome than beneficial, assessments of the likely quality of life for the patient with or without the particular treatment may be one of the appropriate considerations [29].

5. Scotland - Legislation, Case Law

5.1. Developments

The classification of artificial nutrition and hydration as medical treatment has been adopted in Scotland since the case *Law Hospital NHS Trust v Lord Advocate*, (1996) [30] and is now established common law.

5.2. Present situation

Adults with Incapacity (Scotland) Act 2000

The withdrawing or withholding of nutrition and hydration is not specifically mentioned in the *Adults with Incapacity (Scotland) Act 2000*.

However, Section 47 (4) of this Act states that: A *"'medical treatment' includes any procedure or treatment designed to safeguard or promote physical or mental health"*. As such, it is very likely that the withdrawal or the withholding of nutrition and hydration may be considered as medical treatments since they would safeguard or promote physical health.

And in this respect, para 2.34 of the Code or Practice indicates that:

Generally treatment will involve some positive intervention in the patient's condition. Simple failure to do anything for a patient would not be treatment. However a decision not to do something is still an intervention in terms of section 1 principles, and must accord with those principles. It is difficult to conceive of circumstances in which a medical practitioner would take no steps at all in relation to a patient."

Moreover, Section 83 (1) of the Act states that:

It shall be an offence for any person exercising powers under this Act relating to the personal welfare of an adult to ill-treat or wilfully neglect that adult.

In para. 2.62 of the Code of Practice it is indicated that:

"Nothing in the Act authorises acts or omissions which harm, or are intended to bring about or hasten the death of a patient.

During Parliamentary debate on the Act there was extensive discussion of this matter. Ministers made it absolutely clear that the Act does not permit any form of euthanasia, which remains a criminal act under Scots Law.

As the then Deputy Minister for Community Care, Iain Gray, said in the Scottish Parliament,

"Any health professional, like any individual, who acted by any means - whether by withholding treatment or by denying basic care, such as food and drink - with euthanasia as the objective, would be open to prosecution under the criminal law."

All interventions under the Act (including some omissions to act) must comply with the general principles that all interventions must benefit the adult, and that any intervention must be the least restrictive option in relation to the

freedom of the adult. Clearly, an intervention under Part 5 of the Act which adversely affects the well-being of an adult or causes harm or even death to that adult cannot be described as bringing a benefit to that adult.

Finally, para 3.2. of the Code of Practice indicates that:

"... while proxies can legitimately object to particular courses of medical treatment, they may not act unreasonably by, for example, refusing fundamental care procedures."

Case Law

In Scotland, a Court has authorised the withdrawal of artificial nutrition and hydration from a patient in PVS in 1996 [31]. But, unlike in England, the judgement made it explicitly clear that it was not necessary to apply to the Courts in every case where the withdrawal of artificial nutrition and hydration was proposed for a patient in PVS. In other words, though the Court of Session has confirmed its authority to consider such cases it did not make such consideration a formal requirement. The Lord Advocate further indicated that, where such authority has been granted by the Court of Session, the doctor would not face prosecution. This leaves open the possibility of prosecution should the doctor not seek authority from the Court of Session [32].

6. Legislation, Case Law and Regulations - International

6.1. International

European Convention on Human Rights and Biomedicine, ETS - No. 164 [33] (legally binding). Entered into force on 1 December 1999 (the UK has not signed nor ratified this instrument). The following article states that :

Article 5 - General rule

An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks. The person concerned may freely withdraw consent at any time.

6.2. Other countries

To be developed.

7. Links

British Medical Association: Withholding and Withdrawing Life Prolonging Medical Treatemnt: http://www.bmjpg.com/withwith/ww.htm

British Medical Association: End of life issues - withdrawing & withholding treatment

February 2003: http://www.bma.org.uk/ap.nsf/Content/endoflife%3Awithdrawing

Christtian Medical Fellowship :Fluid Infusion and Ethics: http://www.ethicsforschools.org/euthanasia/fluid.htm

General Medical Council, Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making, August 2002, http://www.gmc-uk.org/standards/default.htm

British Medical Association: Withholding and withdrawing life-prolonging medical treatment: Guidance for decision making, http://news.bbc.co.uk/1/hi/health/375981.stm

References

1. General Medical Council, Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making, August 2002, http://www.gmc-uk.org/standards/default.htm

2. Caroline Ashby Nucleus, October 1999, pp4-6

3. This is a similar to the withdrawal or withholding of artificial ventilation when the patient's imminent death is inevitable.

4. Treloar A, Howard P. Tube Feeding: Medical Treatment or Basic Care? Catholic Medical Quarterly, 1998; August: 5-7.

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

6. Wyatt J. Matters of Life and Death. Leicester: IVP/CMF, 1998: 256pp.

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

8. Caroline Ashby Nucleus, October 1999, pp4-6

9. Airedale NHS Trust v Bland [1993].

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

11. See, for example, Frenchay Healthcare NHS Trust v S [1994] 1 WLR 601, Re D (Medical Treatment)[1998] 1 FLR 411.

12. Withholding or Withdrawing Life-prolonging Medical Treatment - Guidance for Decision Making. BMA ethics committee report 1999; Section 21.4.

13. British Medical Association: Withholding and Withdrawing Life Prolonging Medical Treatment: http://www.bmjpg.com/withwith/ww.htm

14. The Law Commission. Report No 231 Mental Incapacity. London: Law Commission, 1995: 90-93.

15. Alexandra Frean, The new line separating life and death, The Times, Saturday 31 July 2004.

16. Charles Foster, Triple Helix - Autumn 2005, The Leslie Burke debacle - Fixing what ain&#65533;t bust (p14), http://www.cmf.org.uk/literature/content.asp?context=article&id=1692

17. Charles Foster, Triple Helix - Autumn 2005, The Leslie Burke debacle - Fixing what ain&#65533;t bust (p14), http://www.cmf.org.uk/literature/content.asp?context=article&id=1692

18. Charles Foster, Triple Helix - Autumn 2005, The Leslie Burke debacle - Fixing what ain&#65533;t bust (p14), http://www.cmf.org.uk/literature/content.asp?context=article&id=1692

19. Airedale NHS Trust v Bland [1993] 1 All ER 821 at page 860 per Lord Keith and page 866 per Lord Goff. Also Re JT (Adult: Refusal of Medical Treatment) [1998] 1 FLR 48 and Re AK (Medical Treatment: Consent) [2001] 1 FLR 129.

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

21. General Medical Council, Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making, August 2002, http://www.gmc-uk.org/standards/default.htm

22. British Medical Association: Withholding and Withdrawing Life Prolonging Medical Treatment: http://www.bmjpg.com/withwith/ww.htm

23. Final responsibility rests with the doctor to decide what treatments are clinically indicated and should be provided to the patient, subject to a competent patient's consent or, in the case of an incompetent patient, any known views of that patient prior to becoming incapacitated and taking account of the views offered by those close to the patient; Re J (A Minor) (Child in Care: Medical Treatment) [1992] 2 All ER 614; and Re G (Persistent Vegetative State) [1995] 2 FCR 46.

24. General Medical Council, Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making, August 2002, http://www.gmc-uk.org/standards/default.htm

25. British Medical Association: Withholding and Withdrawing Life Prolonging Medical Treatment: http://www.bmjpg.com/withwith/ww.htm

26. By the end of September 2000, 23 such cases had been considered by the Courts and two were heard in early October 2000 in which the court confirmed that withdrawing or withholding artificial nutrition and hydration in such circumstances did not contravene the Human Rights Act.

27. British Medical Association: Withholding and Withdrawing Life Prolonging Medical Treatment: http://www.bmjpg.com/withwith/ww.htm

28. Re J (A Minor) (Wardship: Medical Treatment) [1990] 3 All ER 930, Burke, R (on the application of) v General Medical Council & Ors [2005] EWCA Civ 1003 (28 July 2005)

29. Re B [1981] 1 WLR 421; Re C (A Minor) [1989] All ER 782; Re J (A Minor) (Wardship: Medical Treatment) [1990] 3 All ER 930; Re R (Adult: Medical Treatment) [1996] 2 FLR 99.

30. Law Hospital NHS Trust v Lord Advocate, (1996) SLT 848.

31. Law Hospital NHS Trust v Lord Advocate, (1996)

32. British Medical Association: Withholding and Withdrawing Life Prolonging Medical Treatment: http://www.bmjpg.com/withwith/ww.htm

33. Convention on Human Rights and Biomedicine, ETS No.164, http://conventions.coe.int/Treaty/en/Treaties/Word/164.doc