St George's Healthcare NHS Trust v *S*; *Regina* v *Collins and Others, ex parte S*

Neal LJ

[1] I have had the benefit of reading the judgments of my learned colleagues, Judge and Fovargue LJJ, and I am in agreement with their identification of the relevant legal rules. It seems beyond dispute that, according to the present law in England and Wales, the treatment of a competent patient without her consent constitutes the crime of battery and the tort of trespass to the person: In re F (Mental Patient: Sterilisation) [1990] 2 A.C. 1; and that our law therefore contains a rule according to which a patient with capacity has an absolute right to refuse medical treatment: In re T (Adult: Refusal of Medical Treatment) [1993] Fam. 95; Airedale N.H.S. Trust v. Bland [1993] A.C. 789. Likewise, the observation that the human embryo or foetus — at all stages of its development prior to birth — lacks the legal status of 'person' seems incontestable: Burton v. Islington Health Authority [1993] Q.B. 204; In re MB (An Adult: Medical Treatment) [1997] 2 F.C.R. 541; Attorney-General's Reference (No. 3 of 1994) [1998] A.C. 245. In light of these rules, the conclusion reached by my learned colleagues in the case before us seems a difficult one to resist, despite the potentially-tragic implications of that conclusion for any future case in which facts sufficiently similar to the appalling facts of the instant case might arise. Nevertheless, my own analysis of the issues of personal autonomy and foetal status — which are ethical as well as legal issues — differs somewhat from the analyses of my colleagues, and leads me to a different conclusion.

Background to the case

[2] By the time she presented herself to Dr Chill's surgery in London on 25th April 1996, Ms S. had been diagnosed with depression; her relationship with the father of her child had apparently ended recently, and she appears to have indicated that she intended to hand the baby over to him when it was born. She was 'tearful' and 'significantly depressed with low self-esteem', and as my colleague Judge LJ observes, the professionals who interacted with Ms S noted 'a number of contradictions in her position'. We are told, for example, that during the discussion at Dr Chill's surgery, Ms S expressed a preference for 'natural childbirth' (despite having been informed that it would be impossible in her case). This *seems* consistent with her later claim, in her written statement, that:

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> 'I have always held very strong views with regard to medical and surgical treatments for myself, and particularly wish to allow nature to "take its course," without intervention. I fully understand that, in certain circumstances this may endanger my life. I see death as a natural and inevitable end point to certain conditions, and that natural events should not be interfered with. It is not a belief attached to the fact of my being pregnant, but would apply equally to any condition arising.'

Despite her claimed aversion to medical interventions, however, this was a patient who had voluntarily attended two separate doctors' surgeries in the three days prior to writing these words (Dr Keogh's surgery in Surrey, and Dr Chill's surgery in London), and who had previously undergone a termination of pregnancy (in 1993). Ms S is also reported as saying that she 'would not be bothered if she dies and [that] it would be better for the baby to be dead.' A wish that her baby should die is clearly in stark contradiction to a claimed preference for natural childbirth. She is described by Dr Jeffreys as exhibiting 'profound indifference', yet from the narratives available to us, her attitude to the child she was carrying in 1996 resembles antipathy more than indifference. Were this antipathy and her disregard for her own safety connected in any way to the recent demise of her relationship with the child's father? In any case, the fact that Ms S could reach such an advanced stage in her pregnancy without seeking termination implies that her attitude had altered during the course of the pregnancy (the fact that she had previously terminated a pregnancy suggests that she has no principled objection to that practice).

[3] Thus, the practitioners in this case were confronted with an individual who, besides being dangerously and urgently ill, was also distressed, clinically-depressed, and self-contradictory (contradicting herself not only about her attitude to the pregnancy, her reasons for refusing treatment, and her supposed opposition to medical interventions in general, but also about other things such as a claimed antipathy to needles). The overwhelming impression is of someone gripped by a dogged determination to risk both her own life and that of her nearly-born child, in defiance of medical and other professional advice. My colleagues take the view that we must accept all of this as reflecting the valid exercise of Ms S's absolute legal right to refuse treatment; in other words, as an act of self-determination. Much is made by my colleague Judge LJ of the 'articulate' nature of Ms S's written refusal. So if the practitioners' response to her predicament was wrong, what would have been the *right* thing for the

professionals to have done in these circumstances? What is the right thing for the law to do, now?

[4] Every mainstream ethical theory takes, as its implicit or explicit starting-point, the fact that human beings are vulnerable to harm and suffering. To behave ethically is to respond appropriately to the vulnerability of other beings; this will sometimes involve providing them with positive assistance, and sometimes it will involve refraining from causing them harm. Without an acknowledgment of the universal vulnerability of the human condition, it would be difficult to make sense of a whole range of ethical injunctions about how we ought or ought not to treat others, including the familiar bioethical principles of beneficence (the duty to benefit) and non-maleficence (the duty not to harm). Moreover, if universal human vulnerability is what creates the *need* for ethics, it is also what enables the need to be met, since it is the fact that we are *all* vulnerable that makes us *able* to respond appropriately to the vulnerability of others like ourselves. The correct ethical response in this case, as in all cases, consists in responding appropriately to Ms S's vulnerability. I find myself unable to conclude, with my colleagues, that the right thing for the professionals to have done — the appropriate way for them to have responded to Ms S's vulnerability — would have been for them to stand aside and 'respect' Ms S's depressed disregard for her own safety and the safety of the child she said she no longer wanted.

Respect for autonomy and self-determination

[5] The principle of respect for autonomy (and the right of self-determination which it entails) is clearly central within the roll-call of ethical values relevant to the healthcare context: TL Beauchamp and JF Childress, *Principles of Biomedical Ethics* (4th edition, Oxford University Press, 1994). The idea that a person who has the capacity for autonomy is necessarily harmed if her autonomy is interfered with has assumed a totemic status in modern ethical (and particularly *bio*ethical) discourse. Schneider has recently written that 'the law and ethics of medicine are today dominated by one paradigm—the autonomy of the patient': Carl E Schneider, *The Practice of Autonomy: patients, doctors and medical decisions* (New York: Oxford University Press, 1998, 3), and the ultimate manifestation of this triumphant paradigm can be seen in the apparently-absolute right of the competent patient to refuse treatment for any reason or for none, described so powerfully by Lord Donaldson in In re T and by their Lordships in Bland. Lord Reid warns that we must hold fast to it lest we leave

the door ajar for the unlimited erosion of personal freedom: S v McC (orse S) and M (DS intervener); W v. W [1972] A.C. 24, a warning restated by my colleague Judge LJ in the instant case.

[6] We value and respect autonomy not as an abstract phenomenon, however, but as part of the process of valuing and respecting persons. Childress, a leading proponent of the principle of respect for autonomy, has cautioned that it 'is not the only principle, and it cannot be assigned unqualified pre-eminence', and that 'overconcentration' on respect for autonomy can lead to 'neglect of other important moral considerations': JF Childress (1990) 'The Place of Autonomy in Bioethics' 20 *Hastings Center Report* 12–17, 16. He concludes that 'we must not overextend or overweight respect for autonomy' (17). Childress is of course correct to highlight that valuing autonomy is only *part* of the picture when it comes to valuing persons. In some cases, valuing persons will not involve considerations of autonomy at all (in the cases of very young children and adults with incapacity, for example) and in the majority of cases where autonomy *is* present, it will be one value among several that demand consideration. To value respect for autonomy to the extent that we are prepared to sacrifice persons' lives for its sake is, in my opinion, to allow the principle of respect for autonomy to break loose from its ethical moorings — as one consideration within the overall scheme of valuing persons — and run amok. Ms S's autonomy deserves to be respected only because we value Ms S herself; its value is secondary to hers, and we must not fetishize it.

[7] Moreover, whereas according to my colleagues we have a duty to leave Ms S alone, according to one mainstream ethical theory we have an ethical duty to *care for Ms S*: see, e.g., N Noddings, *Caring: A Feminine Approach to Ethics and Moral Education* (Berkeley: University of California Press, 1984). One influential theorist has claimed that '[t]he ideal of care is…an activity of relationship, of seeing and responding to need, taking care of the world by sustaining the web of connection so that no-one is left alone.' (C Gilligan, *In A Different Voice: Psychological Theory and Women's Development*, (Cambridge: Harvard University Press, 1993), 62). It is difficult to see how we could care for Ms S, in the circumstances, by 'leaving her be'. And even if we reject the formal 'ethic of care', I have already suggested that ethics is *inevitably* about responding appropriately to the vulnerability of others (whichever ethical theory one prefers). In my view, if the law requires us to stand aside and recognise Ms S's self-destruction as 'self-determination', it fails to respond appropriately to Ms S's vulnerability.

[8] Nevertheless, it would be disingenuous to pretend that we would be here at all if the loss of Ms S's life were the *only* unwelcome outcome of her treatment refusal. However ethically-questionable it may be to disregard the value of one's own healthy life by refusing non-futile treatment, it is still *more* ethically-problematic to reject treatment where doing so will result in the loss of a life other than one's own. It is because of the threat posed by Ms S's purported refusal to the life of a viable foetus that this matter has ended up before the courts. This court must consider whether or not Ms S has an absolute right to reject the treatment which is essential to save the life of her healthy viable foetus. Although I have said that I agree with my colleagues about which legal rules apply in this case, I also believe that our legal culture and its ethical underpinnings are capable of supporting the *qualification* of the right to refuse treatment contemplated by Lord Donaldson in In re T; namely, where giving effect to refusal would threaten the life of a viable foetus.

The status of the foetus

[9] Like the principle of respect for autonomy from which it flows, the right of self-determination is not absolute or unfettered; it is — *in principle* — qualified and limited. My right to self-determine is limited not only by practical factors such as my *capacity* for self-determination (I cannot self-determine while I am unconscious or lacking in mental capacity), and by the factual possibilities afforded to me (I cannot, for example, choose to belong to a different race, or to be a different height), but also by the rights and interests of others (including *their* rights of self-determination). Just as autonomy is not a natural absolute, likewise the parameters of the associated right of self-determination are limited by the rights of others and by our responsibilities to them.

[10] My colleagues Judge and Fovargue LJJ outline the reasons why foetuses do not count as 'others' under the present law of England and Wales. They provide an accurate account of the legal position, and I take no issue with their analysis on this point. However, my colleague Judge LJ remarks that 'while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment.' I presume that in referring to 'personal responsibilities' Judge LJ intends to denote the pregnant woman's *ethical* responsibilities, as distinct from her legal responsibilities, since one's *legal* responsibilities could hardly increase without there being any consequent

restriction of one's legal *rights*. And if my colleagues (for Butler-Sloss and Walker LJJ join with Judge LJ) do indeed regard the pregnant woman as having increased ethical responsibilities, the obvious question arises: to whom are these increased responsibilities owed? The most plausible answer seems to be: to the child she carries.

[11] I have already stated that, in my view, all of ethics is about responding appropriately to the vulnerability of other beings. The call of *human* vulnerability should resonate within us in a uniquely strong way, however. An inability or unwillingness to recognise and respond to the vulnerability of other humans points up a particular sort of deficiency in our ethical faculties, and bodes ill for the 'broadening out' of our ethical concern to remoter entities. The vulnerability of the human foetus is human vulnerability: as my colleague Judge LJ observes, the human foetus 'is certainly human'; and the vulnerability of a human foetus whose gestational parent is determined to destroy it, either by design or (as in this case) by disregard, is total. It seems to me that such abject human vulnerability should provoke some sort of ethical response from the human moral community; but what nature of response?

[12] In the United States of America, where the foetus also lacks legal personhood, the Supreme Court has held that, *throughout* pregnancy, the State has a legitimate interest in protecting foetal life: Roe v. Wade 410 U.S. 113, 162, reaffirmed in Planned Parenthood of Southeastern Pennsylvania v Casey 505 U.S. 833, 871. The Court confirmed in Casey that:

> 'viability…is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can, in reason and all fairness, be the object of state protection that now overrides the rights of the woman' (505 U.S. 833, 870 referring to Roe v Wade 410 U.S. 113, 163).

In the United States, therefore, the legal non-personhood of the foetus is no obstacle to its being regarded as an appropriate object of state concern, or to that concern becoming sufficiently substantial, at viability, to outweigh the interest of the pregnant woman in autonomously choosing to end her pregnancy.

[13] There is also evidence in our own legal system of the viable foetus being treated as something of value. First, the statutory crime of 'child destruction' in section 1(1) of the

Infant Life Preservation Act 1929 criminalises the deliberate killing of a viable foetus. If a third party were wilfully to injure Ms S in the abdomen, causing the death of her thirty-six week-old foetus, s/he would be liable to be charged with child destruction, *in addition to* being charged with the assault on Ms S herself. Whereas the restriction on late abortion under the Abortion Act 1967 cannot be attributed to a valuing of foetal life, the offence of 'child destruction' *can* be so interpreted, since it criminalises the destruction of the foetus *only,* with any simultaneous harm to the woman punished under separate criminal charges (murder, manslaughter, grievous bodily harm, assault, etc.). Second, in laying the ethical framework for the Human Fertilisation and Embryology Act 1990, the Warnock Committee 'agreed that the embryo of the human species ought to have a special status': *Report of the Committee of Inquiry Into Human Fertilisation and Embryology* (HMSO, 1984), 11.17. If *embryonic* human life deserves to be recognised as having a 'special status', presumably the status of the viable foetus is higher still. We can add to this the judicial acknowledgment by my colleague Judge LJ, in the instant case, that '[w]hatever else it may be a 36-week foetus is not nothing: if viable it is not lifeless and it is certainly human.'

Conclusion

[14] A duty to respect autonomy is (sometimes) part of the overall landscape of ethical obligation; but we are not obliged, at least ethically-speaking, to regard respect for autonomy as paramount. We may choose to respond to Ms S's vulnerability by caring for her, rather than feeling bound to leave her alone. Furthermore, even if we did conclude that we are bound, ethically as well as legally, to regard Ms S's self-destructive refusal of treatment as her own business, the law is nevertheless entitled to take an interest in the life of the viable foetus. The right to self-determination is not absolute, and if ever there were circumstances justifying derogation from it, these are they. I consider that, while it would be preferable to have an exception of the kind contemplated by Lord Donaldson in In re T enacted by Parliament, such an exception is already supported by *existing* legal and ethical principles, and could be made in the instant case. Lord Reid's aforementioned warning about totalitarianism must not go unheeded; however to opt out of the difficult but necessary business of balancing ethical values by simply lionising autonomy is to shirk moral responsibility. The law must have the confidence to draw difficult distinctions.