Legal aspects of dying and the community nurse

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Dying is an inevitable part of life; the dying process has for many years been a medicalised process, and to a greater extent, the law has been shaped by the medical approach to death and dying. To date, there is no statutory definition of death in the UK, but rather death is defined via custom and practice and case law. The accepted standard of death from the Royal Colleges is the 'irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe … and therefore irreversible cessation of the integrative function of the brain stem' (Academy of Medical Royal Colleges, 2008). For patients who are being kept alive through mechanical assistance, such as a life support machine, brain stem death is also accepted as the clinical definition of death as outlined in the case of Airedale NHS Trust v Bland [1993]. Tony Bland had severe brain damage as a consequence of the Hillsborough disaster in 1989. Tony was in a state of post coma unresponsiveness, previously referred to as a persistent vegetative state. In this case, the House of Lords accepted that while Tony Bland had no consciousness, his brain stem was still functioning and was continuing to regulate his heartbeat, breathing and digestion; therefore, he could not be declared dead. However, the House of Lords in recognising his quality of life was extremely poor and there was no expectation of any improvement in his overall condition, gave permission to the hospital for Tony's life-sustaining treatment to be stopped. Tony Bland became the first patient in England and Wales to be permitted by the courts to die because of the withdrawal of life sustaining treatment.

Despite the lack of any statutory definitions, there are numerous laws that cover the dying patient and the patient who has died. Some of these laws are generic laws applicable to a range of situations and not restricted to the dying patient. For example, community nurses need to ensure that as part of their duty of care to patients, the patient who is dying is kept comfortable and pain free, and that they continue to receive the support that is necessary to ensure the patient's needs are being met, as well as providing necessary support to the relatives and carers. Respecting choices remains essential. As an example, a patient may decide to refuse any life-sustaining treatment, and as long as they continue to retain full capacity, the community nurse must honour the patient's autonomy to make a decision regarding their own care, even if the refusal may be seen by the community nurse as an unwise decision. It is also conceivable that over time, patients will see a decline in their mental capacity and thus the law in relation to the Mental Capacity Act 2005 will take effect. For example, the community nurse will need to act in the patient's best interests and must consider the patient's wishes and beliefs.

Advanced decisions are also a part of the Mental Capacity Act and often applicable to patients who are dying and unable to make decisions for themselves, so it is imperative that the community nurse checks to see if an advanced decision has been made before any loss of mental capacity, and if one does exist, and remains valid, this will need to be respected by the community nurse. A person who has a lasting power of attorney for the patient can also make decisions in relation to the care and treatment of the patient without mental capacity, although they cannot demand any treatment to begin or continue when such treatment is deemed not to be in the patient's best interests or would be futile to commence or continue.

The Human Rights Act 1998 via article 2 also states that there is a right to life, and public authorities need to consider a person's right to life when making decisions regarding issues such as life expectancy. While a patient might be terminal, intentionally not treating a patient without a good reason can drastically shorten life and this can be challenged in the courts. Within the Human Rights Act, there is no 'right to die', and at the moment, there is no legal right as to request euthanasia in England and Wales.

Having no state sanctioned right to die brings with it a set of dilemmas for the community nurse. The nurse could be asked by the relatives if they can help hasten the death of a dying person or put an end to their pain, or they may be asked by the patient themselves. While such requests will be rare, the law in England and Wales in relation to euthanasia is clear – while it is not illegal for a person to take their own life under the Suicide Act 1961, aiding and abetting a suicide is illegal. This includes accompanying patients to jurisdictions where euthanasia is legal. In the legal case of R v Cox [1992], Dr Cox, a consultant rheumatologist was asked by Lillian Boyles to end her life. He administered

Abstract

In this month's Policy column, Iwan Dowie explores the legality behind caring for those approaching end of life.

Keywords: end-of-life care • Mental Capacity Act • palliative care

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two ampoules of potassium chloride, which resulted in her death. Dr Cox was charged with attempted murder and was given a 12-month suspended custodial sentence. However, if the community nurse was administrating medication, and the side effect of the medication may hasten death, as long as the medication was being administered for purpose of relieving pain and not for the purpose of hastening death, action against the community nurse is unlikely. It was in the case of R v Bodkin-Adams [1957] that provided healthcare professionals this important legal defence. Bodkin-Adams was administrating life-shortening doses of pain relief medication to many elderly and terminally ill patients, and the patients died. He was charged with murder, which in the 1950s was a capital offence. The judge stated that a doctor is entitled to do all that is proper and necessary to relieve pain and suffering even if such measures may incidentally shorten life. This case also brought into examination the philosophical principle of double effect, where it is permissible to perform an action that can cause a negative effect for which it is not intended (for example suppression of the respiratory system via the use of morphine). Instead, it is the good effect that is the intended outcome (the patient remaining pain free) and not the negative effect.

The law in relation to euthanasia continues to remain controversial and complicated, but it is one that is likely to change over the next few years. Scotland, Jersey and the Isle of Man are all considering some form of assisted dying to allow terminally ill people to end their lives. It is not inconceivable that this would pave the way for the law to be changed in England and Wales. However, safeguards would need to be put in place to ensure that there is no coercion placed upon the person making the decision to end their own life, and it is likely that the community nurse will be included as part of future conversations.

In relation to death, community nurses will, by the very nature of their job, encounter a patient who has died at home. Often the death is expected, for example a patient is palliative, and wishes to die at home, and occasionally the death will be unexpected. If the death was expected, the community nurse can call the GP practice of the deceased and the registered medical practitioner can then issue a medical certificate, which will allow the next of kin to be able to register the death as required by law via the Birth and Deaths Registration Act 1953. If the death took place during the night, there is no need to contact the deceased's GP until the following morning. Registered nurses can also confirm or verify the death, but they cannot issue any death certificate as this remains the domain of the medical practitioner. The police do not normally attend for an expected death.

If the death was unexpected, the community nurse needs to call 999 if this has not been done by the family, and the community nurse may have to start resuscitation of the patient (unless the patient is not for resuscitation) until the paramedic or ambulance crew arrive. It is important that aside from resuscitation, nothing else in the area is touched in case of any suspicions or questions that may arise regarding the death. Where there is no previous decision made by the patient or a medical practitioner not to attempt resuscitation, if there are clear signs of irreversible death, such as rigor mortis, the Nursing Midwifery Council will support the community nurse in making a professional judgement in deciding not to commence resuscitation (NMC, 2020). The police will also attend the patient's home as well as the registered medical practitioner, and if the police decide that there are no indications that the death occurred because of any suspicious activity, the registered medical practitioner can issue a medical certificate to allow the next of kin to continue with arrangements for the deceased patient. If there are any suspicions surrounding the patient's death, the police will make arrangements for the collection of the deceased person to be taken to the mortuary. The death will be reported to the coroner, and the coroner is likely to arrange a post-mortem. The coroner can also hold an inquest into the death, as set out in the Coroners Act 1988. Funeral arrangements cannot begin until the coroner provides their permission. The community nurse can also be summoned as a witness or be asked to write a report or statement for submission to the coroner's court. It is also important to note that patient confidentiality continues after death, and the health records of the patient remain confidential and can only be disclosed to others under limited circumstances. Any breach by the community nurse could lead to professional and legal action. From 9 September 2024, all deaths not reportable to the coroner will be reviewed by a medical examiner who will then discuss the cause of death with the relatives. This is as part of giving a greater voice to the bereaved regarding the care received to the deceased. This is legislated for via The Medical Examiners (England) Regulations 2024. Similar provisions apply to Wales.

Death is therefore very much a part of nursing, and community nurses are in a privileged position to be able to care for and treat people who are dying within their own home. The last dignified care nurses can give a patient is at the time of their death. Whilst there is a legal, professional and ethical duty to always maintain high standards in nursing, it is more imperative that this is upheld during the last moments of life. After death, dignified care continues and community nurses are also entrusted to provide support and advice regarding the next steps to the patient's family and carers. **BJCN**

Declaration of interest: None

Academy of Medical Royal Colleges. A code of practice for the diagnosis and confirmation of death. PPG Design and Print Ltd: London; 2008

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

Nursing and Midwifery Council. Joint NMC/RCN statement regarding decisions relating to cardiopulmonary resuscitation (CPR). 2020. https://tinyurl.com/ypmm5s6c (accessed 20 August 2024)

R v Bodkin-Adams [1957] Crim LR 365

R v Cox [1992] 12 BMLR 38

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