NHS Trust v. Y (by His Litigation Friend, the Official Solicitor): The Right to Withhold and Withdraw Life Sustaining Treatment in the U.K.

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I. OVERVIEW

Mr. Y died before a court could decide he was allowed to.[1] A person's last days should be a reflective and peaceful time for family and loved ones without being inundated by the cost and interference of court proceedings.[2] Mr. Y, a man in his fifties, suffered from an unfortunate cardiac arrest in June 2017, which left him in a persistent vegetative state.[3] Mr. Y required clinically assisted nutrition and hydration (CANH) to keep him alive.[4] Both his treating physician and a second medical opinion concluded that even if he were to regain consciousness, Mr. Y would suffer from severe cognitive and physical deficits and require dependent care for the rest of his life.[5] Consequently, an appeal was submitted to the court to remove CANH from Mr. Y, as both his medical team and family agreed it would be in his best interest.[6] Following custom practice, an Official Solicitor was invited by the court to act as Mr. Y's advocate to petition the case to the Court of Protection.[7] The NHS Trust delivered application to the Queen's Bench Division of the High Court on November 1, 2017, asking for a declaration that (1) it is not mandatory to seek Court approval to withdraw CANH when the family and medical team are in agreement

1. NHS Tr. v. Y [2018] UKSC 46, [7] (appeal taken from Eng.).
2. *Id.* at [121].
3. *Id.* at [3].
4. *Id.*
5. *Id.*
6. *Id.* at [3]-[4].
7. *Id.* at [4], [9].

that it is in the best interest of the patient, and (2) such removal of CANH would not result in any civil or criminal liability.[8]

After review of the request, Ms. Justice O'Farrell denied the transfer to the Court of Protection.[9] Justice O'Farrell reasoned that the application was not a question of best interest for the patient, but rather a legal question of whether common law principles required judicial permission to withdraw CANH from a person who lacks capacity.[10] The Official Solicitor disagreed this was in Mr. Y's best interest and was granted permission to appeal and certify the case directly to the Supreme Court.[11] Unfortunately, Mr. Y died during the appeals process on December 22, 2017, from acute respiratory sepsis while still receiving CANH.[12] Notwithstanding, the Supreme Court continued the proceedings because of the important issues raised by the case.[13] The United Kingdom Supreme Court *held* that if the provisions of the Mental Capacity Act (MCA) 2005 are followed and the relevant guidance observed, and if there is agreement upon what is in the best interest of the patient by both the family and medical care team, then it is not necessary to seek court approval to withdraw CANH from patients in a prolonged disorder of consciousness. *NHS Trust v. Y* [2018] UKSC 46, [2018] WL 03609939 ¶¶ 125-126.

II. BACKGROUND

A. *The "Mental Capacity Act 2005"*

Since its implementation, the MCA 2005 has been the statutory framework in the U.K. for treatment decisions concerning those who lack capacity.[14] As a safeguard, the MCA demands that acts or decisions about health care treatment be made in the best interest of those persons who lack capacity.[15] This includes consideration of a patient's previously articulated wants and wishes through their power of attorney (POA) or advanced directives.[16] If the MCA framework is followed, caregivers are afforded protection from liability to provide appropriate treatment to

8. *Id.* at [4].
9. *Id.* at [5].
10. *Id.*
11. *Id.* at [6].
12. *Id.* at [7].
13. *Id.* at [8].
14. *See generally* Mental Capacity Act 2005, c. 9 (Eng.) (referred to in U.K. cases as the Mental Capacity Act 2005 or MCA).
15. *Id.* c. 9, § 1.
16. *Id.* c. 9, §§ 4, 9-11, 24-26.

patients who lack capacity.[17] Additionally, a patient advocate (such as an official solicitor) may be appointed or provided by the court[18] to act on behalf of the person who lacks capacity.[19] The MCA does not explicitly define the need for court approval to withdraw artificial sustenance from a person in a vegetative state with little or no prospect of recovery.[20]

Similarly, the MCA 2005 Code of Practice (Code of Practice) provides guidance about how to apply the doctrines of the MCA with more detail and instruction on its statutory interpretation and implementation.[21] Specifically, the Code of Practice emphasizes that the final responsibility of determining a patient's best interest, absent an advanced directive or POA, belongs to the medical professional team.[22] Yet, the Code of Practice also endorses the use of the Court of Protection regarding decisions about a patient's best interest if they lack capacity.[23] The Code of Practice document contradicts itself about whether the Court of Protection *must* be enlisted to make such decisions or *should* be involved only as warranted.[24]

The Code of Practice states that "the Court of Protection *must* be asked to make decisions relating to the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from a patient in a permanent vegetative state (PVS),"[25] as well as when conflicts between families and the medical team arise.[26] This would be clear enough alone; however, when describing the role of the Court of Protection, the Code changes its tone.[27] Section 8.19 of the Code states, "[W]ithholding or withdrawing of artificial nutrition and hydration to people in a permanent vegetative state . . . as a matter of practice . . . *should* be put to the Court of Protection for approval."[28] This discrepancy within the Code of Practice further emphasized the need for a resolution on the matter.[29]

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17. *Id.* c. 9, § 5.
18. *Id.* c. 9, §§ 15-17.
19. *Id.* c. 9, §§ 35-38.
20. *See id.* c. 9, Commentary ¶ 65.
21. *Id.* c. 9, § 42; DEP'T FOR CONSTITUTIONAL AFFAIRS, MENTAL CAPACITY ACT 2005 CODE OF PRACTICE Lord Falconor of Thoroton LC, 1, at 1-6 (2007), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf [hereinafter CODE OF PRACTICE].
22. CODE OF PRACTICE, *supra* note 21, at 98-100.
23. *Id.* at 80.
24. *Id.* at 99, 143.
25. *Id.* at 99 (emphasis added).
26. *Id.*
27. *See id.* at 143.
28. *Id.* (emphasis added).
29. *Id.* at 99, 143.

B. Pre-MCA 2005 Domestic Law

Prior to the implementation of the MCA and the Code of Practice, the court struggled to determine what was in the best interest of those patients who lacked capacity.[30] Instead of doctors, Lordships were tasked with determining sensitive and difficult decisions about medical treatment.[31] The case *In re F (Mental Patient: Sterilisation)* considered whether the sterilization procedure of a thirty-six-year-old mentally handicapped woman, who was unable to consent, was an issue to be determined by the court.[32] Under U.K. tort law, it is illegal for a procedure to be performed on a patient without their consent, but a doctor may provide treatment if it is in the best interest of the patient.[33] Because of this uncertainty, the Court reasoned a declaration should be obtained to determine what is in the best interest of the patient.[34] By following this logic, the Court held it was not a strict legal requirement to obtain court permission in every case involving an incapacitated person, but it was good practice that should be continually respected.[35]

Similarly, the House of Lords in *Airedale NHS Trust v. Bland* held that declaratory relief should be sought from the Court before discontinuing life sustaining patient care.[36] Here, a man was left in a persistent vegetative state with no prospect of recovery.[37] Both the patient's family and medical team agreed it would be in his best interest to stop prolonging his life by artificial means.[38] An application was made to the Court for a declaration that CANH could lawfully be discontinued.[39] The House of Lords granted the declaration but emphasized that not all situations could warrant such a declaration, and only after extensive review of the law and facts by the court could such a determination be made.[40]

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30. Helen J. Taylor, *What Are 'Best Interests'? A Critical Evaluation of 'Best Interests' Decision-Making in Clinical Practice*, 24 MED. L. REV. 176, 178-79 (2016).
31. See *id.* at 179-80.
32. F v. W. Berkshire Health Auth. (Mental Health Act Comm'n Intervening) [1989] 2 All ER (HL) 545, [549]-[550] (appeal taken from Eng.) (also known as *In re* F (Mental Patient: Sterilisation)).
33. *Id.* at [550]-[551].
34. *Id.* at [549]-[550].
35. *Id.* at [552].
36. Airedale NHS Tr. v. Bland [1993] 1 All ER (HL) 821, [833] (appeal taken from Eng.).
37. *Id.* at [832].
38. *Id.* at [825], [832]-[833].
39. *Id.* at [825]-[826].
40. *Id.* at [858].

Conversely, court declaration was sought from a patient while he had capacity to ensure treatment would *not* be withdrawn as his degenerative condition worsened in *In re Burke*.[41] The patient reasoned that failure to seek guidance would go against his common law rights under the European Convention on Human Rights (ECHR).[42] The Master of the Rolls, Lord Phillip, concluded that there was no legal duty to obtain court authorization before withdrawing CANH under either case law or the ECHR.[43] The court further cited the decision of the European Court of Human Rights (ECtHR) in *Glass v. United Kingdom*, which likewise concluded that such an appeal is not required by law.[44] The ECtHR clarified that one may still seek to obtain legal advice about controversial treatments, and medical care teams should always take into consideration a patient's prior expressed wishes, but "any more stringent legal duty would be prescriptively burdensome."[45]

C. Post-MCA 2005 Decisions and Other Relevant Guidance

After the MCA set the statutory standard for determining those cases in which persons lacked capacity, courts continued to look to case law for interpretation of what is in a patient's best interest.[46] In *Aintree University Hospitals NHS Foundation Trust v. James*, the hospital Trust applied for declaration from the court to withdraw certain life-saving measures from a patient, who lacked capacity, if his medical condition were to worsen.[47] The patient's family disagreed that withdrawal of such treatment would be in the patient's best interest or wishes.[48] The patient's condition eventually did worsen.[49] He was completely dependent on mechanical ventilation and would pass away from cardiac arrest, leaving behind a widow who would carry an appeal to the Supreme Court.[50] After the patient's death, the Supreme Court focused on what it meant for treatment to be in a

41. R (Burke) v. Gen. Med. Council (Official Solicitor & Others Intervening) [2005] EWCA (Civ) 1003 [2], [5] (Eng.) (also known as *In re* Burke).

42. *Id.* at [14] (citing Eur. Conv. on H.R. arts. 2, 3, 6, 8, 14, Sept. 3, 1953 (Council of Eur.)).

43. *Id.* at [70]-[74].

44. *Id.* at [80] (citing Burke v. United Kingdom, App. No. 19707/06, Eur. Ct. H.R. 8 (2006)).

45. *Burke*, Eur. Ct. H.R. at 8; Glass v. United Kingdom, 39 Eur. Ct. H.R. 15 at [82] (2004).

46. Mental Capacity Act 2005, c. 9, § 4 (Eng.).

47. Aintree Univ. Hosps. NHS Found. Tr. v. James [2014] 1 All ER 67 [573], [578]-[579] (appeal taken from Eng.).

48. *Id.*

49. *Id.* at [579]-[580].

50. *See id.* at [580].

patient's best interest within the scope of the MCA and Code of Practice.[51] Baroness Hale emphasized the fundamental legal question is really whether it is lawful *to give* treatment, not *withhold* it.[52] The Court explained that any medical team that withdraws treatment because it is not in the patient's best interest, even without court approval, would not be penalized.[53]

Conversely, *In re M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment)* interpreted the MCA to follow those cases requiring court approval to legally withdraw CANH.[54] Judge Baker relied heavily upon *Bland*, with the understanding that it set a legal standard requiring court permission to remove life-sustaining treatment from patients in a minimally conscious state.[55] Judge Baker grounded his belief in the uncertainty of medical science evolution and stressed that independent court oversight was necessary to ensure a patient's best interest was being met.[56]

In re M (Incapacitated Person: Withdrawal of Treatment) arrived at a contrary conclusion through a separate analysis.[57] In that case, Judge Jackson held that there was no statutory obligation to appeal to the court for a decision to withdraw CANH, especially when both the medical team and family agreed it would be in the patient's best interest.[58] Judge Jackson recognized precedent established court application as a matter of good practice, but only for those decisions where removal was contended.[59] He further pointed out the removal of CANH was no different than the removal of any other life-sustaining treatment and should not be treated differently.[60] Plus, he added, mandatory litigation about these decisions might dissuade medical professionals from implementing what is in the best interest of the patient for fear they will later need to argue their reasoning in court.[61]

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51. *Id.* at [577].
52. *Id.* at [581].
53. *Id.* at [587]-[589].
54. W (by her litigation friend, B) v. M (by her litigation friend, the Official Solicitor) [2012] 1 All ER [1313], [1387]-[1391] (also known as *In re* M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment)).
55. *Id.* at [1328], [1336]-[1340].
56. *Id.* at [1328].
57. *See generally* M (by her litigation friend, Mrs. B) v. Hospital [2018] 2 All ER [551], [563]-[565] (also known as *In re* M (Incapacitated Person: Withdrawal of Treatment)).
58. *Id.* at [564]-[566].
59. *Id.* at [560]-[561], [566].
60. *Id.* at [564].
61. *Id.*

On a broader scale, the same considerations have been considered by EU courts as well; *Lambert v. France* concerned a dependent tetraplegic man with irreversible brain damage who was receiving artificial nutrition and hydration.[62] After a dispute between the patient's medical team and family about withdrawing artificial nourishment, the case was heard by the ECtHR for claims of violating the ECHR.[63] The ECtHR held a patient's medical team may, after family consultation and an objective second medical opinion, make the decision to withdraw care if it is in the patient's best interest.[64] The ECtHR noted three distinct safeguards that should be in place to bypass court involvement in the withdrawal of life sustaining treatment: (1) there is a legal framework in place to guide such decisions, (2) a patient's prior expressed wishes are honored, and (3) the courts are available in situations of dispute.[65] The court further recognized that consensus among the treating physician and family was the most common mechanism to reach these same decisions in different countries as well.[66]

Lastly, aside from legal precedent and statutory interpretation, U.K. courts have looked to various medical guidance to direct their decisions about withdrawing life-sustaining treatment.[67] An Interim Guidance document produced by the Royal College of Physicians (RCP), the General Medical Council (GMC), and British Medical Association (BMA) in 2017 specifically addressed the withdrawal of CANH from minimally conscious patients.[68] It stated, absent an advance decision or POA, what is in the best interest of a patient may be made by their physician after a second clinical opinion has been sought and family consultation has concurred.[69] The Interim Guidance established that there

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62. Lambert v. France, 62 Eur. Ct. H.R. 57, 61 (2016).
63. *Id.* at [83]-[84], [99]-[100], [103].
64. *Id.* at [102]-[104].
65. *Id.* at [91]-[92], [98]-[100], [102]-[103].
66. *Id.* at [79], [81]-[82], [99]-[100].
67. BRITISH MED. ASS'N, GEN. MED. COUNCIL & ROYAL COLL. OF PHYSICIANS, DECISIONS TO WITHDRAW CLINICALLY-ASSISTED NUTRITION AND HYDRATION (CANH) FROM PATIENTS IN PERMANENT VEGETATIVE STATE (PVS) OR MINIMALLY CONSCIOUS STATE (CMS) FOLLOWING SUDDEN-ONSET PROFOUND BRAIN INJURY 1 (2017) [hereinafter INTERIM GUIDANCE]; ROYAL COLL. OF PHYSICIANS, PROLONGED DISORDERS OF CONSCIOUSNESS: NATIONAL CLINICAL GUIDELINES 61-64 (2013); GEN. MED. COUNCIL, TREATMENT AND CARE TOWARDS THE END OF LIFE: GOOD PRACTICE IN DECISION MAKING 57-59 (2010). *See generally* BRITISH MED. ASS'N, WITHHOLDING AND WITHDRAWING LIFE-PROLONGING MEDICAL TREATMENT: GUIDANCE FOR DECISION MAKING (2007).
68. *See generally* INTERIM GUIDANCE, *supra* note 67.
69. *Id.* at 3.

are cases where no court guidance is needed; however, in situations of dispute, appeal to the court should be sought to assist with the decision.[70]

III. THE COURT'S DECISION

In the noted case, the U.K. Supreme Court followed the same reasoning as *In re Burke*[71] and *In re M (Incapacitated Person: Withdrawal of Treatment)*,[72] extending the privilege of deciding what is in a patient's best interest to their medical team and family without the legal requirement of court approval.[73] The Court understood case precedent and the MCA to mean the withdrawal of CANH from a minimally conscious patient as best practice without court permission when there is no dispute between the family, medical team, or objective second medical opinion.[74] The Court also considered broader case law and statutory interpretation to focus on the fundamental question of law: whether it is lawful to *provide* treatment to a patient who is not able to make their own decision, rather than *withdraw* it.[75]

The noted case was not naïve to *Bland*'s wishes of a legal requirement for application to the court in all cases where CANH is removed from patients with PVS.[76] However, because this idea rested upon the pre-MCA case interpretation of *In re F*, where there was also the same desire, it ultimately would have made new law, which is not within the power of the courts.[77] Instead, the noted case recognized application to the court for declaratory relief as simply good practice.[78]

In Re Burke carried this further and recognized the same requirement as a simple recommendation.[79] However, the noted case condemns the reasoning in *In re M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment)* because it misinterpreted *Bland* in establishing a legal requirement to gain court approval before removing CANH and

70. *Id.*
71. *See In re* Burke [2005] EWCA (Civ) 1003 [49]-[50].
72. *In re* M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment), EWCOP 19 [37]-[38] (2017).
73. NHS Tr. v. Y [2018] UKSC 46, [125]-[126] (appeal taken from Eng.).
74. *Id.*
75. *Id.* at [92].
76. *Id.* at [93]; *see also* Airedale NHS Tr. v. Bland [1993] 1 ALL ER 821 (HL) 833 (appeal taken from Eng.).
77. *See Y* [2018] UKSC 46 at [93]; *In re* F (Mental Patient: Sterilisation) [1989] 2 ALL ER 545 (HL) 545-46 (appeal taken from Eng.).
78. *Y* [2018] UKSC 46 at [93].
79. *Id.* at [94]; *In re* Burke [2005] EWCA (Civ) 1003 [80].

therefore cannot be used to bolster the Solicitor's argument here.[80] Ultimately, the noted case held that there is no domestic law requirement to appeal to the court for patient protection against the withdrawal of CANH when there is agreement among the medical team and family.[81]

Similarly, the U.K. Supreme Court did not interpret the MCA to include a universal requirement to gain court approval prior to withdrawing CANH but indicates these decisions should be made with the patient's best interest in mind.[82] There is a provision about court intervention for personal welfare as necessary, but the MCA does not spell out specific examples of those situations that must always be appealed.[83]

Curiously, the MCA Code of Practice does suggest some areas that may benefit from court intervention, but the Court noted that the document contradicts itself about when this should occur.[84] Paragraph 6.18 reads that the court "must make," whereas paragraphs 8.18-8.19 indicate such application "should be" as "a matter of practice."[85] The noted case emphasized that, although the MCA gives weight to the Code of Practice, "it does not create an obligation as a matter of law to apply to court in every case."[86]

To further its point, the noted case analogizes the MCA to the French case *Lambert v. France*.[87] The French code requires a patient's care team to give primary regard to a patient's previously expressed wishes and those of their next of kin.[88] They are also required to consult with their doctor and obtain the opinion of an independent consultant.[89] The Court explained that the same core concepts are required through the MCA, including court availability as necessary.[90] Although the U.K., unlike France, does not have an established legal code of guarantees for each situation, this does not preclude the U.K. from complying with those mandates made by the ECHR and the ECtHR.[91]

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80. *Y* [2018] UKSC 46 at [99]; *see also In re* M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment) [2012] 1 All ER 1313, 562; *Bland* [1993] 1 ALL ER at 833.
81. *Y* [2018] UKSC 46 at [102].
82. *Id.* at [120]-[124]; Mental Capacity Act 2005, at "Best Interests," c. 9, § 4 (Eng.).
83. *See generally* Mental Capacity Act 2005, at "Best Interests," c. 9, § 4 (Eng.).
84. *See* CODE OF PRACTICE, *supra* note 21, at 6.18, 8.18-8.19.
85. *Id.*
86. *Y* [2018] UKSC 46 at [97].
87. *Id.* at [103]-[105]; Lambert v. France, 62 Eur. Ct. H.R. 57, 97-98 (2016).
88. *Lambert*, 62 Eur. Ct. H.R. at 81.
89. *Id.* at 71, 75-76.
90. *Y* [2018] UKSC 46 at [103], [105]-[109].
91. *Id.*

The noted case emphasized that the ECtHR has repeatedly set out three relevant factors about administering or withdrawing treatment.[92] The first is a regulatory framework and domestic law compatible with Article 2.[93] The Court made the argument that the MCA is the U.K.'s version of a regulatory framework and that this conforms with the ECtHR's standards as the basic protective structure for U.K. human rights.[94] It expanded upon the multidisciplinary approach taken to establish the framework used in the U.K. to protect at-risk patients including the MCA and other supplemental authorities such as the GMC, BMA, and RCP.[95] The second factor protecting a patient's previously expressed wishes about medical treatment is also umbrellaed under the MCA, along with the third option of petitioning the court in case of a disagreement about the patient's best interest.[96]

Moreover, the ECtHR has already considered the U.K.'s domestic provisions of these requirements in *Burke v. United Kingdom*.[97] The ECtHR did not find any of the three regulatory requirements lacking in the U.K. and recognized that a legal obligation to appeal to the court for approval to withdraw CANH *in every case* would be "prescriptively burdensome."[98] Such safeguards are in place to petition the court for those occasions where there is still a dispute or question beyond the guidance of the MCA framework.[99]

The noted case further underlined that the abstention of treatment as a focus requires a big picture view and exercise of restraint.[100] In areas of social and ethical uncertainty, courts are limited to deciding only those legal issues.[101] But medical treatment is beyond the scope of court practice and best left to those experienced in the matter, such as the medical care team.[102] Noting the *Bland* case, CANH is a form of medical treatment and should not be treated differently than other life-sustaining treatment that

92. *Id.* at [105]-[109].
93. *Id.* at [105].
94. *Id.* at [105]-[109].
95. *Id.*
96. *Id.* at [108]-[109].
97. *Id.* at [111]. *See generally* Burke v. United Kingdom, App. No. 19707/06, Eur. Ct. H.R. 8 (2006).
98. *Y* [2018] UKSC 46 at [115]; *Burke*, Eur. Ct. H.R. at 8.
99. *Y* [2018] UKSC 46 at [111]-[113].
100. *Id.* at [112]-[113], [115].
101. *Id.* at [115].
102. *Id.*

does not require court appeal.[103] Nor should just one subset of patients, those with PVS, fall under different legal requirements than other patient subsets where withdrawal of CANH is "made on a regular basis without recourse to the courts."[104]

The final holding of the noted case touched upon the argument that court decisions for removal of CANH could be made within a reasonable time frame and that an appeal to the court is needed because of scientific advancement.[105] Although few cases have been decided in a reasonable amount of time, this is the exception and an overly optimistic view of court efficiency.[106] The Court pointed out the distressing emotional and financial hardships a patient and that patient's family would endure while waiting for a court decision.[107] Moreover, required court permission may create an inappropriate continuation of unnecessary treatment, or even reluctance to start CANH, and deter families from making decisions about what is really best for the patient.[108] With regard to continually developing medical science, the Court turned to the MCA requirement of a second objective opinion to ensure the best interest of the patient is being met to reduce diagnostic error, premature decisions, and evaluative measures.[109]

Overall, the U.K. Supreme Court found in the noted case that, through domestic law and the ECHR, there is no mandatory requirement for court involvement to decide what is in the best interest of the patient when removing CANH so long as the provisions of the MCA are followed.[110] More importantly, the Court emphasized that application to the court may be beneficial when there is a dispute regarding care between the medical team and the patient's family.[111] Ultimately, the Official Solicitor's appeal was dismissed.[112]

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103. *Id.* at [116]-[118] (noting that decisions regarding medical treatment in the acute care setting (such as emergencies) are often made without patient participation by the clinical team and patient families on the basis of the best interest of the patient and CANH should not be treated any differently); Airedale NHS Tr. v. Bland [1993] 1 All ER 821 (HL) 827 (appeal taken from Eng.).

104. *Y* [2018] UKSC 46 at [117]-[119] (discussing that patients with PDOC should not be treated differently than patients with neurological conditions to withdraw CANH where it is better understood that such withdrawal would lead to natural death as would removal of any medical treatment).

105. *Id.* at [120]-[124].

106. *Id.* (citing the Solicitor's argument proposing eight weeks' time as a general timeframe for all court cases involving the withdrawal of CANH).

107. *Id.* at [124].

108. *Id.* at [121].

109. *Id.* at [122]-[124]. *See generally* Mental Capacity Act 2005, c. 9 (Eng.).

110. *Y* [2018] UKSC 46 at [125]-[126].

111. *Id.*

112. *Id.* at [126].

IV. ANALYSIS

NHS v. Y sets the stage for further U.K. court interpretation of social and ethical morals that skirt along the edge of the law. The Court spurned the Official Solicitors' interpretation of both case law and the MCA to dismiss the appeal while simultaneously ruling such an appeal as unnecessary if the relevant guidance is followed.[113] The Court took certain liberties in its interpretation and shed light on the importance of MCA understanding, but overall provided sound legal reasoning and appropriate deference to nonlegal expertise and guidance.[114]

The Court made the right decision for two reasons: it made a once ambiguous issue entirely clear while also progressing social policy by handing back a patient's best interest to their family and trusted medical professionals. The case follows the path of *Burke* by analyzing the same three factors and utilizing the MCA as a regulatory framework with the Court as a catchall for those cases of controversy.[115] Historically, case law about the issue has been equivocal, and in a way the noted case fits squarely within domestic case law: none of the cases explicitly held that application to the court was necessary; opinions simply alluded to it as best practice.[116] What's most significant is the Court's interpretation of the MCA and actually admitting that it contradicts itself.[117] The U.K. Court looks beyond itself to interpret the impact such a decision would have, not just legally, but on a larger scale for those faced with the impossible decision.[118] By establishing that the MCA means "should," and not "must," the Court weakened the rumored legal requirement while still allowing domestic case law to stand true in best practice appeals to the court as necessary.[119]

The Court used a nontraditional analysis of domestic case law to reach its final position on, not just on the withdrawal of CANH from a person with prolonged disorders of consciousness (PDOC), but also a general stance on life-sustaining treatment for minimally conscious patients with little hope of improvement.[120] The Court followed the precedent set by *Burke* that explicitly held court permission for the

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113. *Id.* at [125]-[126]
114. *Id.* at [43]-[48], [75]-[77]; *see also* INTERIM GUIDANCE, *supra* note 67, at 3.
115. *Y* [2018] UKSC 46 at [111]-[113]; *In re* Burke, [2005] EWCA (Civ) 1003 [2], [15] (Eng.).
116. *See Y* [2018] UKSC 46 at [91]-[126].
117. *Id.* at [97], [107].
118. *Id.* at [115].
119. *Id.* at [126].
120. *Id.*

withdrawal of treatment from a patient with PVS is only a recommendation and not a court requirement.[121] This conflicted with both *Bland* and *In re F,* which alluded that "best practice" lingered on the line of a legal requirement.[122] Although the Official Solicitor attempted to argue that a person with PDOC is different than a patient with PVS, the Court rightfully generalized their standing to all "minimally conscious patients" and extended their holding to analogize CANH to other life-sustaining measures that have overtly been decided not to require court intervention.[123] As the medical guidance suggested, the differences between these types of patients are too minute to require a separate analysis of each.[124]

Furthermore, the Court's analysis of the MCA and the MCA Code of Practice is equally sagacious.[125] Most significant is the Court's posture on the MCA 2005 Code of Practice; instead of equivocating, the Court maintains its integrity through forthright admission that the Code contradicts itself through a confusing mixture of "should" and "must."[126] Despite this, the Court correctly concluded that the Code of Practice itself is not a statute, and therefore the Solicitor Official's statutory interpretation of it is meritless.[127] The actual statute, the MCA 2005, is absent of any legal requirement to appeal to the Court and should be correctly followed.[128] Moreover, the Court bolsters its argument by establishing the MCA 2005 as part of the framework meeting the requirements set forth by the ECtHR, which further clarified there was no legal requirement.[129] Overall, the noted case provided judicial scrutiny to a long debated subject and answered many of the questions that paved the road to the decision reached here.

V. CONCLUSION

The noted case will have a significant social and legal impact on future cases of similar issue that attempt to consider what is in a patient's best interest. In a time of science and social progression, some may see

121. *Id.* at [111]; Burke v. United Kingdom, App. No. 19707/06, Eur. Ct. H.R. at 8 (2006).
122. Airedale NHS Tr. v. Bland [1993] 1 All ER 821 (HL) 858 (appeal taken from Eng.); *In re* F (Mental Patient: Sterilisation) [1989] 2 All ER 545 (HL) 545-46 (appeal taken from Eng.).
123. *Y* [2018] UKSC 46 at [84]-[85], [117].
124. *Id.* at [123]; *see* INTERIM GUIDANCE, *supra* note 67, at 6.
125. *Y* [2018] UKSC 46 at [42]-[48].
126. *Id.* at [97], [126].
127. *See id.* at [97].
128. *Id.*
129. *Id.* at [105]-[108].

such decisions as compassionate while others may fear such rulings indicate the removal of extra protections for defenseless patients. Most significantly, the noted case alleviates the financial and emotional stress added that litigation would place upon families already facing an impossible decision. Overall, the decision in the noted case gives those patients without a voice the security of knowing their prior wishes will be upheld, without extraneous measures prolonging the inevitable.

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