THE MEDICO-LEGAL DEVELOPMENT OF NEUROLOGICAL DEATH IN THE UK, BY KARTINA A CHOONG (SPRINGER, 2023, c£44 PB/EBOOK)

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This crisp (75 page) book by Kartina A. Choong, Reader in Medical Law and Ethics at the University of Central Lancashire, provides an extremely useful overview of how death has become to be understood not only as a cardio-respiratory matter, but also as a neurological matter, and an examination of the consequences of this within the United Kingdom. It also develops a thesis that the role of the courts in formalising and endorsing the clinical understanding of neurological death has been unhelpful, and that the definition of death should be a matter for Parliament.

The opening chapter, "Death Revisited," outlines how the traditional understanding of death (i.e. that respiration and circulation has stopped) started to be accompanied in the mid-20th century by a parallel understanding of death as the cessation of brain function. Choong sketches out how this understanding arose as a result of the increasing use of mechanical ventilation in modern intensive care units, enabling – often – respiration and circulation to be maintained indefinitely, and raising the question of the point at which it could or should be said that the person was nonetheless dead. As she identifies, this question was also tangled up with the development of approaches to organ donation – organs from those who have died from cardiac failure, for instance, will have been starved of blood and oxygen for a period of time, and will therefore not necessarily be in the best condition for transplantation. The ethical dilemma to which this gives rise in terms of the incentive to classify a ventilator-dependent patient as dead in order to obtain high quality organs is a clear one, and Choong traces its unfolding in the international context in concise and clear fashion.

In the second chapter, "The Emergence of Neurological Death in the United Kingdom," Choong turns to the UK context, and the role of the Conference of Medical Royal Colleges and Their Faculties (now the Academy of Medical Royal Colleges (AOMRC)). Interestingly, as she identifies, in the Conference's first statement on the matter (in 1976), it did not follow the approach taken in the United States in equating brain death with the demise of the person. Rather, the statement identified that a diagnosis of brain death was an indicator of futility; ventilation and other life-sustaining treatment could be withdrawn, not because the patient was dead, but because they had no chance of recovery. Three years later, in an addendum, the Conference made the shift to brain death as equating to the death of the person. Choong is critical of this addendum for having identified no basis for its "glaring leap in interpretation" (page 17); she is also critical more generally of the guidance for the fact that it did not make clear what role those with an interest in securing organ donations had played in it. She then traces through the development of guidance, both as to the diagnosis of what was (by 1995) being identified as "brain stem death", rather than "brain death,"

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and as to the relevance of brain stem death for organ donation, leading to the most recent (at the time of writing) guidance, the AOMRC's 2008 *Code of Practice for the Diagnosis and Confirmation of Death*, and the Royal College of Paediatrics and Child Health (RCPH)'s 2015 recommendations in relation to children aged under 2 months old. As Choong notes (page 23), the 2008 Code of Practice "*made a conscious and deliberate effort to decouple the diagnosis and confirmation of death from organ donation and transplantation. This was to presumably ward off criticism that the diagnosis of brain stem death is inextricably linked to the desire to obtain organs for transplantation*." No doubt reflecting when work started upon them, and in what is otherwise a work which is otherwise admirably up-to-date (ncluding as it does detailed discussion of the 2022 case of Archie Battersbee) the chapter does not note that the AOMRC is currently undertaking an update of the 2015 guidance, and the RCPCH are also updating an update of their 2015 recommendations.[1]

In Chapter 3, Choong turns to law's response to the introduction and development of death by neurological criteria in clinical practice. She highlights through a careful and comprehensive review of the case-law both how and why these criteria came before the courts, and how the dialogue between the courts and the clinicians unfolded. Foreshadowing her argument in Chapter 4, she is at pains to emphasise the extent to which it was the courts, rather than Parliament, which have given legitimacy to the clinical criteria enshrined in the guidance. One consequence of this, she argues, is that very short shrift has been given to arguments based upon religious conceptions of the point of death which, in the United States, have found their way into legislation such as the New Jersey's Declaration of Death Act 1991. This Act provides that death cannot be declared on the basis of neurological criteria "*when the licenced physician authorised to declare death, has reason to believe, on the basis of information in the individual's available medical records, or information provided by a member of the individual's family or any other person knowledgeable about the individual's personal religious beliefs that such a declaration would violate the personal religious beliefs of the individual*." In such circumstances, death can be declared only on the basis of cardio-respiratory criteria. Attempts to run such arguments have failed before the English courts in cases such as *Re A (A Child)* [2015] EWHC 443 (Fam), as have arguments based upon the diagnostic criteria used in other jurisdictions. Rather, as Choong highlights, the Court of Appeal has made clear that "*it is impossible for this court now to embark upon an assessment of whether a different test…should replace the long established UK criteria represented in modern times by the 2008 Code and the 2015 Guidance*."[2]

In Chapter 4, Choong develops the argument that Parliament should be involved in the consideration of what constitutes death. The heart of her argument (at page 53) is that judges have only been:

> invited to adjudicate on a narrow set of circumstances. In the situations discussed, it was clear that the agenda also dictates how the decision was made. The question posed to the judges was whether a ventilated patient in ICU was dead and whether it would be lawful to withdraw their

[1] Details of the latter can be found at https://www.rcpch.ac.uk/resources/diagnosis-death-neurological-criteria-infants-less-two-months-old-clinical-guideline (accessed 31 March 2023).
[2] *Re M (Declaration of Death of Child)* [2020] EWCA Civ 164

> ventilation. Judges in turn perceived and framed their task as one to find out what are the criteria used by doctors to determine death, and whether these were satisfied in the circumstances. Thus rather than asking how should death be determined, or whether the definition and criteria used by the medical profession are sufficiently robust, their angle of inquiry saw to it that the diagnosis and criteria used by the Conference, and later the Academy, received legal endorsement. It also led to the exclusion of other alternative definitions and determinations of death. In this way, ventilators can be removed from patients who are brain stem dead even if they are considered still alive in other jurisdictions and from a religious perspective. Such an uncompromising stance is taken without being preceded or informed by its own independent research or of wider consultation or debate—as these are not, as mentioned above, within the scope of judicial decision-making. Neither would the making of exceptions or reasonable accommodation be fitting, as they have a responsibility to ensure that the law is clear and consistent.

At the same time, however, Choong observes that:

> By recognising that brain stem dead patients are legally dead, the judiciary indirectly legitimised heart-beating organ donation since vital organs are retrieved from patients who are considered to have died.

Demonstrating perhaps a slightly rose-tinted perspective on Parliamentary processes, Choong considers that, whilst Parliamentary intervention would not be to consider the acceptability of the idea of diagnosing death by neurological criteria, it would provide an opportunity to debate and deliberate upon the robustness of the existing formulation and criteria of death; and the feasibility and significance of religious exemption in relation to the withdrawal of artificial ventilation. I say slightly "rose-tinted" perspective because, with honourable exceptions (most often to be found in the House of Lords) Parliamentarians have not, perhaps, always shown itself at their best when it comes to debating issues relating to life and death. If there were to be a move towards codifying the definition of death in statute, I would certainly make a (biased[3]) plea towards involving the Law Commission as an intermediary step to maximise the chances of making a law which works.[4]

A final chapter pulls the threads together, leaving the reader well equipped to understand both the history of where we have come from and to interrogate the updating guidelines forthcoming from the AORMC and the RCPH. I look forward to the next edition of this book in which Choong casts her expert eye over them.

[3] As a former secondee there.

[4] As to which, see the fascinating recent book by David Goddard, Making Laws That Work: How Laws Fail and How We Can Do Better (Hart, 2022).