

(Burke) v General Medical Council

Queen's Bench Division(Admin): Munby J : 30 July 2004

Guidance published by the General Medical Council, "Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-Making", was amenable to judicial review in so far as it was erroneous in point of law. In so far as that guidance (1) placed the emphasis throughout on the right of the competent patient to refuse treatment rather than on his right to require treatment; (2) failed sufficiently to acknowledge that it was the duty of a doctor who was unable or unwilling to carry out the wishes of his patient to go on providing the treatment until he could find another doctor who would do so; (3) failed sufficiently to acknowledge the heavy presumption in favour of life-prolonging treatment and to recognise that the touchstone of best interests was intolerability, so that if life-prolonging treatment was 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; and (4) failed to spell out the legal requirement to obtain prior judicial sanction for the withdrawal of artificial nutrition and hydration in certain circumstances, it was incompatible with the claimant's rights under common law and under arts 2, 3 and 8 as scheduled to the 1998 Act, not to deprive a person of his life intentionally, not to subject him to inhuman or degrading treatment, and not to interfere with his physical and psychological integrity and dignity.

MUNBY J so declared in the Queen's Bench Division when allowing an application for judicial review by the claimant, Mr Oliver Leslie Burke, of guidance issued by the defendant, the General Medical Council, "the GMC".

The claimant, who suffered from a congenital degenerative brain condition, sought clarification as to the circumstances in which artificial nutrition and hydration (ANH) might lawfully be withdrawn.

MUNBY J said that the issues related to two broad questions: first, the circumstances in which it was lawful for doctors to withhold or withdraw ANH and, secondly, the circumstances in which (if at all) that decision had first to be referred to a court.

In relation to the common law: (1) Once a patient had been received or admitted into a NHS hospital a duty to care arose - to provide and continue treatment - whether the patient was competent or incompetent, conscious or unconscious. (2) Once the duty arose, the doctor and the hospital were under a continuing obligation that could not lawfully be shed unless arrangements were made for the responsibility to be taken over by someone else. (3) The duty to care was, in principle, a duty to provide that treatment which was in the best interests of the patient. (4) The evaluation of a patient's best interests involved a welfare appraisal in the widest sense. (5) Doctors could properly claim expertise on medical matters; but they could claim no special expertise on the many non-medical matters which went to form the basis of any decision as to what was in a patient's best interests. (6) In the final analysis it was for the patient, if competent, to determine what was in his own best interests. If the patient was incompetent and had left no binding and effective advance directive then it was for the court to decide what was in his best interests. (7) Personal autonomy - the right of self-determination - and dignity were fundamental rights, recognised by the common law and protected by arts 3 and 8. (8) The personal autonomy protected by art 8 embraced such matters as how one chose to pass the closing days and moments of one's life and how one manages one's death. (9) The dignity interests protected by the Convention included, under art 8, the preservation of mental stability and, under art 3, the right to die with dignity and the right to be protected from treatment, or from a lack of treatment, which would result in one dying in avoidably distressing circumstances. (10) An enhanced degree of protection was called for under arts 3 and 8 in the case of the vulnerable. (11) If the patient was competent (or, although incompetent, had made an advance directive which was both valid and relevant to the treatment in question) his decision as to where his best interests lay, and as to what

life-prolonging treatment he should or should not have, was in principle determinative⁽¹²⁾ If the patient was incompetent, the test was best interests. There was a very strong presumption in favour of taking all steps which would prolong life, and save in exceptional circumstances, or where the patient was dying, the best interests of the patient would normally require such steps to be taken. In case of doubt that doubt fell to be resolved in favour of the preservation of life. But the obligation was not absolute. Important as the sanctity of life was, it might have to take second place to human dignity. In the context of life-prolonging treatment the touchstone of best interests was intolerability.

Health authorities, NHS trusts and their staff were clearly public authorities for the purposes of the Human Rights Act 1998 and were, as such, bound to act in a manner compatible with the patient's rights under the Convention. Arts 2, 3 and 8 primarily imposed negative obligations on the state: not to deprive a person of his life intentionally, not to subject him to inhuman or degrading treatment, and not to interfere with his physical and psychological integrity and dignity. Personal autonomy and dignity were fundamental rights, not merely recognised by the common law but also protected by arts 3 and 8. And just as the common law recognised that, important as the sanctity of life was, it had to take second place to personal autonomy and might have to take second place to human dignity, so likewise did the Convention. Art 8 protected not merely the patient's dignity but also, and crucially, the patient's personal autonomy: see *NHS Trust A v M*, *NHS Trust B v H* [2001] Fam 348 and *Pretty v United Kingdom* (2002) 35 EHRR 1.

Art 3 prohibited "torture" and "inhuman or degrading treatment or punishment": and see *D v United Kingdom* (1997) 24 EHRR 423. However unconscious or unaware of ill-treatment a particular incompetent adult or a baby might be, treatment which had the effect on those who witnessed it of degrading the individual could come within art 3. Treatment was capable of being "degrading" if judged by the standard of right-thinking bystanders it would be viewed as humiliating or debasing the victim, showing a lack of respect for, or diminishing, his or her human dignity. In relation to the withdrawal of ANH: (a) Under the Convention, as at common law, if the patient was competent (or, although incompetent, had made an advance directive which was both valid and relevant to the treatment in question) his refusal to accept ANH was determinative. (b) If the patient was competent (or, although incompetent, had made an advance directive which was both valid and relevant to the treatment in question) his decision to require the provision of ANH which he believed was necessary to protect him from what he saw as acute mental and physical suffering was likewise in principle determinative. (c) To withdraw ANH at any stage before the claimant finally lapsed into a coma would in principle involve clear breaches of both arts 8 and 3; for it was clear that if ANH were to be withdrawn he would be exposed to acute mental and physical suffering. (d) The position of an incompetent patient was likely in practical terms to be the same. If ANH was 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. (e) It was hard to envisage any circumstances (other, perhaps, than those envisaged by Professor Higginson) [where the provision of ANH to a patient with severe and deteriorating dementia could be very distressing] in which a withdrawal of ANH in such circumstances - that is from a sentient patient, whether competent or incompetent - could be compatible with the Convention. (f) Assuming that the patient was otherwise being treated with dignity, and in a manner which was in all other respects compatible with his rights under arts 3 and 8, there would not be any breach either of article nor of art 2 if ANH was withdrawn in circumstances where it was serving absolutely no purpose other than the very short prolongation of the life of a dying patient who had slipped into his final coma and lacked all awareness of what was happening. (g) Where it was proposed to withhold or withdraw ANH the prior authorisation of the court was required as a matter of law (i) where there was any doubt or disagreement as to the capacity (competence) of the patient; or (ii) where there was a lack of unanimity amongst the medical professionals as to the patient's condition or prognosis or his best interests or the likely outcome of ANH being either withheld or withdrawn or otherwise; or (iii) where there was evidence that the patient when competent would have wanted ANH to continue in the relevant circumstances;

or (iv) where there was evidence that the patient (even if a child or incompetent) resisted or disputed the proposed withdrawal of ANH; or (v) where persons having a reasonable claim to have their views or evidence taken into account asserted that withdrawal of ANH was contrary to the patient's wishes or not in the patient's best interests.

In the light of the relevant principles, the legal content of the Guidance was properly vulnerable to criticism. It followed that the claimant had in principle established his right to relief.

Appearances: *Richard Gordon QC* and *Clive Lewis* (instructed by Ormerods Incorporating Coningsbys, Croydon) for the claimant; *Dinah Rose* (instructed by Field Fisher Waterhouse, London, EC3)for the defendant; *David Wolfe* (instructed by Head of Legal Services, Disability Rights Commission) for the interested party, the Disability Rights Commission; *Robert Francis QC* (instructed by the Treasury Solicitor) for the intervener, the Official Solicitor to the Supreme Court.

Reported by: Carolyn Toulmin, barrister.