Case No: C1/2004/2086

Neutral Citation Number: [2005] EWCA Civ 1003
IN THE SUPREME COURT OF JUDICATURE
COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT (ADMINISTRATIVE COURT)
THE HONOURABLE MR JUSTICE MUNBY
[2004] EWHC 1879 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Thursday, 28 July 2005

Before :

LORD PHILLIPS OF WORTH MATRAVERS, MR
LORD JUSTICE WALLER
and
LORD JUSTICE WALL

- -

Between :

The Queen on the Application of OLIVER LESLIE BURKE	**Respondent**
- and -	
THE GENERAL MEDICAL COUNCIL	**Appellant**
-and-	
THE DISABILITY RIGHTS COMMISSION **THE OFFICIAL SOLICITOR TO THE SUPREME COURT** **CATHOLIC BISHOPS' CONFERENCE OF ENGLAND AND WALES** **THE SECRETARY OF STATE FOR HEALTH** **PATIENT CONCERN** **MEDICAL ETHICS ALLIANCE** **ALERT** **BRITISH SECTION FOR THE WORLD FEDFRATION OF DOCTORS WHO RESPECT HUMAN LIFE** **INTENSIVE CARE SOCIETY**	**Interveners**

- -

(Transcript of the Handed Down Judgment of
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David Wolfe (instructed by the **Head of Legal Services**) for the **Intervener: the Disability Rights Commission**

Robert Francis QC and Caroline Harry-Thomas (instructed by the **Official Solicitor**) for the **Intervener: the Official Solicitor to the Supreme Court**

Eleanor Sharpston QC & Angela Patrick for the **Intervener: the Catholic Bishops' Conference of England and Wales**

Philip Sales and Jason Coppel for the **Intervener: the Secretary of State for Health**

Leigh Day for the **Intervener: Patient Concern**

James Dingemans QC (instructed by **Messrs Barlow Robbins, Solicitors**) for the **Interveners: Medical Ethics Alliance, ALERT, & the British Section of the World Federation of Doctors Who Respect Human Life**

Messrs Mills & Reeve, Solicitors for the Interveners: the Intensive Care Society

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Judgment

Lord Phillips MR

This is the judgment of the court to which all members have contributed.

Introduction

1. With permission granted by the judge, the General Medical Council ('GMC') appeals against six declarations made by Munby J on 30 July 2004 in proceedings for judicial review instituted against it by Oliver Leslie Burke. Three of those declarations relate specifically to Mr Burke. The remaining three declare unlawful a number of paragraphs of a document of guidance published by the GMC in August 2002 entitled *Withholding and Withdrawing Life-prolonging Treatment: Good Practice and Decision Making ('the Guidance').* We have set out the relevant passages from the Guidance in an appendix to this judgment. The appeal raises, as its central issue, the circumstances in which artificial nutrition and hydration ('ANH') can be withdrawn from a patient.

Mr Burke's predicament

2. Mr Burke is 45 years of age. He suffers from a congenital degenerative brain condition known as spino-cerebellar ataxia, which currently confines him to a wheelchair. The judge described the course that his illness is likely to follow in these terms:

> "3. This is a progressively degenerative condition that follows a similar course to multiple sclerosis. He was diagnosed in 1982. He suffers very serious physical disabilities but has retained his mental competence and capacity. He has gradually lost the use of his legs and is now virtually wholly dependent on a wheelchair for mobility. He has uncoordinated movements and his condition also affects his speech, but his mental ability is not impaired. "
>
> 4. By reason of his condition there will come a time when the claimant will be entirely dependent on others for his care and indeed for his very survival. In particular he will lose the ability to swallow and will require ANH by tube to survive.
>
> 5. The medical evidence indicates that the claimant is likely to retain full cognitive faculties even during the end stage of this disease and that he will retain, almost until the end, insight and awareness of the pain, discomfort and extreme distress that would result from malnutrition and dehydration. (If food and water were to be withheld he would die of dehydration after some two to three weeks.) He is also likely to retain the capacity to experience the fear of choking which could result from attempts at oral feeding. The medical evidence also indicates that the claimant is unlikely to lose his capacity to make decisions for himself and to communicate his wishes until his death is imminent. An eminent consultant in neurology

and rehabilitation medicine describes what he calls "the likely scenario during the final days of Mr Burke's life" as follows:

> "he will by then be bed bound and communicating via a computerised device. He would then become unwell with either a chest or urinary tract infection and within a few days would become increasingly obtunded and lose the ability to use his communication aid. If medical treatment for the underlying infection is unsuccessful he would become progressively weaker and semi-comatose and then succumb."

3. The judge elaborated on this picture a little later in his judgment

> "48. In the present case I am concerned with a patient who at present is manifestly competent and who, however distressing his condition and his symptoms, is likely to remain competent, with his senses and his awareness substantially unimpaired, long into the terminal stages of his illness, indeed in all probability until he is fairly close to death. The evidence makes clear that until his final days the claimant, although by then being kept alive by ANH, will retain both his capacity to make decisions for himself and an ability to communicate his wishes, albeit probably via a computerised device. During his final days he will lose the ability to communicate, although not at first an awareness and appreciation of his surroundings and predicament. He will then lapse into a semi-comatose condition before dying."

4. No one contemplating Mr Burke's predicament could fail to feel for him the greatest sympathy and, in our case, that sympathy was augmented by awareness of Mr Burke's dignified presence in court during the hearing of this appeal.

Mr Burke's concern

5. The judge described Mr Burke's concern as follows:

> "The claimant wants to be fed and provided with appropriate hydration until he dies of natural causes. He does not want ANH to be withdrawn. He does not want to die of thirst. He does not want a decision to be taken by doctors that his life is no longer worth living."

This reflected a passage in the annexe to Mr Burke's claim form, which stated:

> "He is concerned that doctors will determine for him whether or not he ought to continue to live and whether or not a decision should be taken to withhold or withdraw life-prolonging treatment in the form of artificial nutrition and hydration."

6. In a witness statement Mr Burke described how, at the Lancaster Disablement Information and Support Centre ('DISC'), he became aware of the Guidance. He went on to say:

> "6. I understand that the General Medical Council is a charity whose purpose is the protection by promotion of the health and safety of the community. The role of the GMC is to protect patients. I believe that the said guidance that has been issued fails to offer such protection. I am concerned that too much power is placed in the hands of the medical profession. Paragraph 32 of the said guidance materially provides:
>
> > "If you are the consultant or general practitioner in charge of a patient's care, it is your responsibility to make the decision about whether to withhold or withdraw a life-prolonging treatment, taking account of the views of the patient or those close to the patient as set out in paragraphs 41-48 and 53-57."
>
> 7. I wish to be involved in deciding the treatment I receive as much as possible. I am aware that as my condition deteriorates it is highly likely that I will eventually lose capacity. The guidance gives no advice on how the question of incapacity is to be determined.
>
> 8. I am further concerned that even if my death is not imminent, a doctor may be able to withdraw artificial nutrition and hydration. Paragraph 81 materially provides:
>
> > "Where death is not imminent, it usually will be appropriate to provide artificial nutrition or hydration. However, circumstances may arise where you judge that a patient's condition is so severe, the prognosis so poor, that providing artificial nutrition or hydration may cause suffering or to be too burdensome in relation to the possible benefits."
>
> 9. I anticipate that the progression of my condition will result in me having more suffering than I do at the present time. I am very worried that artificial nutrition and hydration could be withdrawn.
>
> 10. I am also concerned that there appears to be no legal forum within which my rights can ultimately be protected. There is no obligation upon a doctor to seek the advice of a Court as to whether and when my life should be ended."

7. Neither the judge's summary of Mr Burke's concern, nor his own statement, sets out with clarity the precise nature of his concern. In order to appreciate this it is necessary to identify with some nicety the different circumstances in which, in theory at least, ANH might be withdrawn from a patient.

8. The body requires food and water to live. The evidence was that, if deprived of food and water, a patient will die of the lack of these in approximately 14 days. A patient who cannot or will not swallow food and water may be kept alive by ANH. But the administering of ANH will not keep a patient alive for ever. Ultimately the patient will die, even if ANH continues to be administered. Where a patient is in the final stages of a terminal disease the administration of ANH will cease to prolong life, and in some cases may even hasten death.

9. It is important to distinguish between the withdrawal of ANH in circumstances where this will shorten life and the withdrawal of ANH where it will not have this effect because it is no longer sustaining life. This distinction is, in practice, not always easy to draw. For instance, the evidence showed that a patient may, as part of the process of dying, cease to eat or drink. In such circumstances the administration of ANH may delay, to some extent, the dying process.

10. It is also important to distinguish between (1) withdrawal of ANH from a patient who is competent, (2) withdrawal of ANH from a patient who is sentient but not competent and (3) withdrawal of ANH from a patient who is not sentient because, for instance, he is in a permanent vegetative state (PVS) or has lapsed into a coma at the end of a terminal illness. A patient is competent if he has the capacity to take logical decisions and the ability to communicate those decisions.

11. The evidence was that Mr Burke will remain competent until the final stage of his disease. Thus, so long as ANH was prolonging his life, he will be able, albeit with the aid of a computerised device, to communicate his wish, if such it remains, that those caring for him should continue to administer ANH. He will lose competence in the final stages of his disease, first losing the ability to communicate while remaining sentient, and shortly thereafter lapsing into a coma. During these final stages ANH will cease to be capable of prolonging his life.

12. If Mr Burke fears that ANH will be withdrawn before the final stages of his disease, it is implicit that he fears that those caring for him may decide that his life is not worth living and withdraw ANH to bring it to an end, notwithstanding that he is able to communicate to them that he wishes them to continue to keep him alive. Paragraphs 7, 8 and 9 of his statement suggest that this is his primary concern. He wishes "to be involved in deciding the treatment I receive as much as possible".

13. We must state at once that, if this is Mr Burke's fear, there is no reason for him to have it. There are no grounds for thinking that those caring for a patient would be entitled to or would take a decision to withdraw ANH in such circumstances. Nor, as we shall show, did the Guidance suggest to the contrary. Had Mr Burke been well advised he would and could have sought reassurance from the GMC as to the purport of their guidelines and from the doctors who were treating him as to the circumstances, if any, in which ANH might be discontinued.

14. Mr Burke did not take that course. The manner and circumstances in which these proceedings were commenced suggest that he was persuaded to advance a claim for judicial review by persons who wished to challenge aspects of the GMC Guidance which had no relevance to a man in Mr Burke's position. Thus his Claim Form sought the following declarations:

"(1) A declaration that paragraphs 32, 38 and 81 of the Guidance issued by the General Medical Council entitled "Withholding and Withdrawing Life-Prolonging Treatment: Good Practice in Decision-Making" are unlawful as the advice contained in those paragraphs is incompatible with Articles 2, 3, 6, 8 and 14 of the European Convention on Human Rights.

(2) A declaration that a patient is entitled to have the question of whether or not care in the form of artificial nutrition and hydration withdrawn resolved by a court or tribunal in accordance with Article 6(1) ECHR.

(3) A declaration that, where death is not imminent, the withholding or withdrawal of artificial nutrition and hydration, leading to death by starvation or thirst, not through natural causes would necessarily be a breach of the Claimant's rights under Article 2, 3 and 8 of ECtHR and would be unlawful under domestic law.

(4) A declaration that where death is imminent, the withholding or withdrawal of artificial nutrition or hydration with the result that he would die of starvation or thirst, not of natural causes, would necessarily:

(1) be a breach of his rights under Article 2, 3 and 8 and would be unlawful under domestic law or

(2) alternatively would be a breach of his rights under Article 2, 3 and 8 and unlawful under domestic law unless there were some compelling interest that meant that it could not be in his interests for that treatment to be provided and that there was a compelling interest that he should be left to dies of starvation and thirst rather than natural causes."

15. In the course of the hearing before Munby J, Mr Gordon QC revised the relief that he sought on behalf of Mr Burke to the following declarations:

"(1) the withholding or withdrawal of artificial nutrition and hydration, leading to death by starvation or thirst would be a breach of Mr Burke's rights under Articles 2, 3, and 8 and would be unlawful under domestic law;

(2) where a competent patient requests or where an incompetent patient has, prior to becoming incompetent, made it clear that they would wish to receive artificial nutrition and hydration, the withholding or withdrawal of artificial nutrition and hydration, leading to death by starvation or thirst would be a breach of their rights under Articles 2, 3 or 8 and would be unlawful under domestic law;

(3) the refusal of artificial nutrition and hydration to an incompetent patient would be a breach of Article 2 unless providing such artificial nutrition and hydration would amount to degrading treatment contrary to Article 3;

(4) the Guidance … is unlawful in so far as it fails it safeguard the rights of patients under Articles 2, 3 and 8;

(5) paragraph 81 of Guidance … is unlawful as it is incompatible with Article 2, 3 and 8 and domestic law;

(6) withdrawal of artificial nutrition and hydration from a non-PVS patient without first seeking a court ruling in circumstances where artificial nutrition and hydration would not be withdrawn from a PVS patient is unlawful discrimination contrary to Article 14;

(7) paragraph 81 of Guidance … is unlawful as it is incompatible with Article 14;

(8) where there is disagreement between a competent patient, or relatives or carers of an incompetent patient, as to whether artificial nutrition should be withdrawn, the disagreement should be resolved by application to a court or, alternatively, that those proposing to withdraw artificial nutrition and hydration should inform the patient or relatives and carers and afford them sufficient time before withdrawal of artificial nutrition and hydration to enable them to take steps to secure their rights under Articles 2, 3 and 8."

16. Despite the revision the relief claimed still extended far beyond that necessary to allay any apprehensions that Mr Burke might have in relation to his personal predicament.

17. The reaction to Mr Burke's claim of the Official Solicitor, who intervened, is instructive. His skeleton argument began by observing that Mr Burke's anxieties related to "the withdrawal of ANH from adult patients who are unable to make their own decisions". He then went on to state:

> "4(a) It is the wish of the Official Solicitor to assist the Court as much as possible in the resolution of this case. To this end he will offer submissions in relation to various issues potentially raised by it. However, he will offer only limited comments on the particular merits of the Claimant's case for a number of reasons:
>
> (i) The Claimant is clearly mentally competent at the moment, is not receiving or in need of ANH. Therefore, as matters stand, the question does not arise as to whether a decision to withdraw ANH should be made with or without his consent;

(ii) The medical evidence adduced by Mr Burke does not suggest that he will lose the mental capacity to consent to or refuse treatment.

(iii) There is no evidence that any medical practitioner likely to treat the Claimant and to be in a position to administer, withhold or withdraw ANH intends to apply the GMC guidance in the manner feared by the Claimant.

(iv) On the evidence produced so far, the Official Solicitor is of the view that, were he to be called upon to express a view now on the matter, he would not consider it in the Claimant's best interests for ANH to be withdrawn if he continued to express a wish that it be continued. However, if the treatment required by the Claimant becomes a matter of dispute or concern at a time when he is mentally incapable of taking decisions for himself, the Official Solicitor may well become involved on behalf of the Claimant in declaratory or other proceedings. At such a time the Official Solicitor would be in the position to undertake the necessary inquiries with regard to the Claimant's best interests and his previously expressed wishes to an extent that is neither practicable nor desirable at this stage. The issues would have to be judged on the circumstances at the time.

(v) In these circumstances there is some danger to the Claimant in seeking so to define the law in his case as to prevent or inhibit what might be thought to be highly desirable treatment or changes in treatment at a later stage."

18. We entirely agree with this analysis. However, the Official Solicitor (unfortunately) continued in paragraph 4(b) to say:

> "For these reasons the Official Solicitor, unless requested to do otherwise by the Court, intends to restrict himself to the consideration of the wider issues raised by the Claimant's application, which it is suggested, are of general public importance."

19. Mr Francis QC, instructed by the Official Solicitor, submitted to us that Mr Burke had performed a public service by enabling these wider issues to be debated. We do not agree. The judge himself observed that it was not the task of a judge when sitting judicially – even in the Administrative Court – to set out to write a text book or practice manual. Yet the judge appears to have done just that. There is perhaps no one who, as practitioner and judge, has had greater experience of this area of the law, and it is perhaps this experience that has led Munby J to produce a judgment 225

paragraphs long. Many of those paragraphs are extremely lengthy. In the specialist law reports it occupies the best part of 100 pages. It ranges widely over what the judge described at the start of his judgment as "fundamentally important questions of medical law and ethics".

20. Munby J's judgment has, understandably, been seen as extending well beyond the approach to patients in the position of Mr Burke, or the use of ANH. Indeed it has been understood as bearing on the right to treatment generally, and not merely life prolonging treatment. It has led to the intervention in the proceedings before us of the Secretary of State for Health, Patient Concern, Medical Ethics Alliance, Alert, the British Section of the World Federation of Doctors Who Respect Human Life, the Intensive Care Society and the Catholic Bishops Conference of England and Wales.

21. There are great dangers in a court grappling with issues such as those that Munby J has addressed when these are divorced from a factual context that requires their determination. The court should not be used as a general advice centre. The danger is that the court will enunciate propositions of principle without full appreciation of the implications that these will have in practice, throwing into confusion those who feel obliged to attempt to apply those principles in practice. This danger is particularly acute where the issues raised involve ethical questions that any court should be reluctant to address, unless driven to do so by the need to resolve a practical problem that requires the court's intervention. We would commend, in relation to the Guidance, the wise advice given by Lord Bridge of Harwich in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 at 193-4:

> "… the occasions of a departmental non-statutory publication raising … a clearly defined issue of law, unclouded by political, social or moral overtones, will be rare. In cases where any proposition of law implicit in a departmental advisory document is interwoven with questions of social and ethical controversy, the court should, in my opinion, exercise its jurisdiction with the utmost restraint, confine itself to deciding whether the proposition of law is erroneous and avoid either expressing ex cathedra opinions in areas of social and ethical controversy in which it has no claim to speak with authority or proffering answers to hypothetical questions of law which do not strictly arise for decision."

The judge himself cited this passage with approval. Unfortunately he did not follow it.

22. The judge made the following declarations:

> "(1) Any decision by the claimant while competent, or contained in a valid advance directive, that he requires to be provided with artificial nutrition and hydration is determinative that such provision is in the best interests of the claimant at least in circumstances where death is not imminent and the claimant is not comatose;

(2) Where the claimant has decided, or made a valid advance directive, that he wishes to be provided with artificial nutrition and hydration, any refusal by a hospital who has assumed the care of the claimant to arrange for the provision of such artificial nutrition and hydration at any time until the claimant's death is imminent and the claimant is comatose would be a breach of the claimant's rights under Article 3 and Article 8 of the European Convention on Human Rights;

(3) Where the claimant has decided, or made a valid advance directive, that he wishes to be provided with artificial nutrition and hydration and where a doctor has assumed the care of the claimant, the doctor must either continue to arrange for the provision of artificial nutrition and hydration or arrange for the care of the claimant to be transferred to a doctor who will make such arrangements, in the period until the claimant's death is imminent and the claimant is comatose;

(4) Paragraph 81 of the Guidance issued by the General Medical Council entitled "Withholding and Withdrawing Life-prolonging Treatment: Good Practice in Decision-making" is unlawful in that (a) it fails to recognise that the decision of a competent patient that artificial nutrition and hydration should be provided is determinative of the best interests of the patient (b) it fails to acknowledge the heavy presumption in favour of life-prolonging treatment and that such treatment will be in the best interests of a patient unless the life of the patient, viewed from that patient's perspective, would be intolerable and (c) provides that it is sufficient to withdraw artificial nutrition and hydration from a patient who is not dying because it may cause suffering or be too burdensome in relation to the possible benefits;

(5) Paragraphs 13, 16, 32 and 42 of the Guidance issued by the General Medical Council entitled "Withholding and Withdrawing Life-prolonging Treatment: Good Practice in Decision-making" are unlawful as they fail to recognise that the decision of a competent patient on whether artificial nutrition and hydration is determinative in principle of whether or not such treatment is in the patient's best interest;

(6) Paragraphs 38 and 82 of the Guidance issued by the General Medical Council entitled " Withholding and Withdrawing Life-prolonging Treatment: Good Practice in Decision-making" are unlawful as they fail to reflect the legal requirement that in certain circumstances artificial nutrition and hydration may not be withdrawn without prior judicial authorisation but provide that it is sufficient to consult a clinician with relevant experience or to take legal advice.

The first three declarations were extraordinary in nature in that they did not purport to resolve any issues between the parties, but appeared to be intended to lay down propositions of law binding on the world.

The declarations as a whole go far beyond the current concerns of Mr Burke in that (1) they deal with the position of an incompetent patient, when, on the evidence, Mr Burke is likely to remain competent until the final stages of his illness and (2) they address the effect of an advance directive, sometimes referred to as 'a living will', when Mr Burke has made no such directive. We do not overlook the fact that there is likely to be, some years hence, a short period before Mr Burke lapses into his final coma when he will be sentient but unable to communicate his wishes. The implications of withdrawal of ANH at that stage may depend critically on the effect, if any, that this will have on easing his final conscious moments. The appropriate approach to Mr Burke's treatment at that final stage may depend upon any informed wishes that he may have expressed after explanation of these implications and of the options for therapeutic care that will be available. We do not understand Mr Burke's current concerns to relate to this stage and, if they do, we think that they are premature.

Our approach to this appeal

23. We have come to the clear view that this appeal must be allowed, and the declarations made by the judge set aside. It is our view that Mr. Burke's fears are addressed by the law as it currently stands and that declaratory relief, particularly in so far as it declares parts of the Guidance unlawful, is both unnecessary for Mr. Burke's protection and inappropriate as far as the Guidance itself is concerned.

24. This approach does, however, leave us with a difficulty in relation to Munby J's judgment. The judge's erudition and industry are self-evidently on display throughout its 225 paragraphs. A great deal of what is contained in the body of the judgment is uncontroversial. Having taken the view, however, that much of the judge's industry is misplaced, it would plainly be inappropriate for this court to respond with a judgment of equal length, or one which examined in detail issues which we deem irrelevant to the actual issues raised by the case. On the other hand, it is equally inappropriate to leave the judgment to be seized on and dissected by lawyers seeking supportive material for future cases. Although we have said that a great deal in the body of the judgment is uncontroversial, we counsel strongly against selective use of Munby J's judgment in future cases.

25. We propose first to address those passages of Munby J's judgment which deal with Mr Burke's concern that ANH may be withdrawn, despite the wishes that he expresses while he remains competent. We will then respond shortly to those parts of the judgment, and they are the major parts, which do not relate to this concern.

Concern at the possible withdrawal of ANH from Mr Burke while he is competent and expresses the wish to continue to receive ANH

26. The following parts of the declarations made by Munby J relate to this concern:

    i) Mr Burke's decision that he requires ANH is determinative that this is in his best interests (Declaration 1).

ii) Withdrawal of ANH contrary to Mr Burke's expressed wish would breach his rights under Article 3 and 8 of the European Convention on Human Rights ('the Convention') (Declaration 2).

iii) Where Mr Burke expresses that he wishes to receive ANH a doctor who has assumed his care must either provide it or arrange for someone else to provide it (Declaration 3)

iv) Paragraphs 13, 16, 32 and 42 and 81 of the Guidance are unlawful in that they fail to recognise that a decision of a patient that he wishes to receive ANH is in his best interests (Declarations 4 and 5)

We will deal with each of these in turn.

Best interests and autonomy

27. A theme running through Munby J's judgment is that, provided that there are no resource implications, doctors who have assumed the care of a patient must administer such treatment as is in the patient's best interests and that, where a patient has expressed an informed wish for a particular treatment, receipt of such treatment will be in the patient's best interests. This theme thus equates best interests with the wishes of the competent patient. Paragraphs 88 to 115 of his judgment are devoted to developing this theme in terms which range over the position both where the patient is competent and where he is incompetent.

28. In this section of his judgment, Munby J draws a distinction between the *Bolam* [1997] 1 WLR 582 test, which on his analysis focuses simply on treatment that is in the interests of the patient from a clinical viewpoint, and the test of best interests which "involves a welfare appraisal in the widest sense, taking into account where appropriate, a wide range of ethical, social, moral, emotional and welfare considerations".

29. We do not find this lengthy passage of intense jurisprudential analysis, which owes much to cases involving compulsory sterilisation of incompetent patients, helpful in approaching the situation of a competent patient who needs ANH to remain alive and who communicates his wish to receive it. The concept of 'best interests' depends very much on the context in which it is used, as indeed does the *Bolam* test, but neither is of much relevance when considering the situation with which we are concerned. In *Airedale NHS Trust v Bland* [1993] AC 789 members of the House of Lords observed that the wishes of a patient might conflict with his best interests (see Lord Goff of Chievely at p. 864 C to E and Lord Mustill at p. 891H). It seems to us that it is best to confine the use of the phrase 'best interests' to an objective test, which is of most use when considering the duty owed to a patient who is not competent and is easiest to apply when confined to a situation where the relevant interests are medical.

30. Using 'best interests' in this way it is apparent that treating a patient in the manner that doctors consider to be in his best interests may be at odds with his wishes. To take an extreme example, a patient who is in desperate clinical need of a blood transfusion and who has no wish to die may, for religious reasons, not wish to receive one although the consequence is almost certain death. Where a competent patient makes it clear that he does not wish to receive treatment which is, objectively, in his

medical best interests, it is unlawful for doctors to administer that treatment. Personal autonomy or the right of self determination prevails.

31. The proposition that the patient has a paramount right to refuse treatment is amply demonstrated by the authorities cited by Munby J in paragraphs 54 to 56 of his judgment under the heading '*Autonomy and self-determination'*. The corollary does not, however, follow, at least as a general proposition. Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. Insofar as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it. The source of the duty lies elsewhere.

32. So far as ANH is concerned, there is no need to look far for the duty to provide this. Once a patient is accepted into a hospital, the medical staff come under a positive duty at common law to care for the patient. The authorities cited by Munby J at paragraphs 82 to 87 under the heading '*The duty to care*' establish this proposition, if authority is needed. A fundamental aspect of this positive duty of care is a duty to take such steps as are reasonable to keep the patient alive. Where ANH is necessary to keep the patient alive, the duty of care will normally require the doctors to supply ANH. This duty will not, however, override the competent patient's wish not to receive ANH. Where the competent patient makes it plain that he or she wishes to be kept alive by ANH, this will not be the source of the duty to provide it. The patient's wish will merely underscore that duty.

33. Insofar as the law has recognised that the duty to keep a patient alive by administering ANH or other life-prolonging treatment is not absolute, the exceptions have been restricted to the following situations: (1) where the competent patient refuses to receive ANH and (2) where the patient is not competent and it is not considered to be in the best interests of the patient to be artificially kept alive. It is with the second exception that the law has had most difficulty. The courts have accepted that where life involves an extreme degree of pain, discomfort or indignity to a patient, who is sentient but not competent and who has manifested no wish to be kept alive, these circumstances may absolve the doctors of the positive duty to keep the patient alive. Equally the courts have recognised that there may be no duty to keep alive a patient who is in a persistent vegetative state ('PVS'). In each of these examples the facts of the individual case may make it difficult to decide whether the duty to keep the patient alive persists.

34. No such difficulty arises, however, in the situation that has caused Mr Burke concern, that of the competent patient who, regardless of the pain, suffering or indignity of his condition, makes it plain that he wishes to be kept alive. No authority lends the slightest countenance to the suggestion that the duty on the doctors to take reasonable steps to keep the patient alive in such circumstances may not persist. Indeed, it seems to us that for a doctor deliberately to interrupt life-prolonging treatment in the face of a competent patient's expressed wish to be kept alive, with the intention of thereby terminating the patient's life, would leave the doctor with no answer to a charge of murder.

Would withdrawal of ANH contrary to the wishes of Mr Burke infringe Articles 3 and 8 of the Convention?

35. Munby J's consideration of the effect of the Convention spans paragraphs 117 to 214 - that is nearly half - of his judgment. His conclusion, as we understand it, was that Article 2 of the Convention would not be infringed if the doctors ceased to provide ANH to Mr Burke contrary to his expressed wishes, but that Article 3 would be infringed because the effect would be to subject Mr Burke to acute mental and physical suffering and Article 8 would be engaged because Mr Burke's dignity and autonomy would have been flouted.

36. In this section of his judgment Munby J ranged widely over a mass of jurisprudence, giving consideration to the position of Mr Burke if ANH were withdrawn thereby causing him to die in a manner that involved acute mental and physical suffering. In doing so he considered the position of a patient who was both competent and incompetent. He identified three stages that Mr Burke might pass through: the first when he was competent and aware, the second when aware of his surroundings and predicament but unable to communicate, and the third after lapsing into a coma. He assumed that Mr Burke would, by the time he reached the second stage, have made an advance directive. He postulated that to withdraw ANH in the first or second stage would infringe Mr Burke's Article 3 and Article 8 rights. As to the final stage, he said:

> "175. Whether there will in fact be a breach either of Article 3 or of Article 8 if ANH is withdrawn from the claimant once he has entered into the third and final stage and has finally lapsed into a coma is not a matter capable of decision this far in advance of an event which, as I understand it, is unlikely to occur for many years yet. I decline therefore to express any conclusion on the point.
>
> 176. Much may turn upon the precise terms of the claimant's advance directive. More importantly, much will depend upon the claimant's condition once that stage is reached. It may be that by then – and on the evidence before me we are probably talking here only about the last few hours of life – ANH will be serving absolutely no purpose other than the very short prolongation of the life of a dying patient who has slipped into his final coma and who lacks all awareness of what is happening. In that event it might very well be said that the continuation of ANH would be bereft of any benefit at all to the claimant and that it would indeed be futile."

37. As to this reasoning, we would comment that it is not clear to us that ANH will prolong Mr Burke's life at stage 2 or 3, nor that if he decides to make an advance directive, this will necessarily require that he be given ANH on the chance that this will gain him a few more hours or days of life, provided that its cessation will not be likely adversely to affect his comfort before he lapses into coma. We do not consider that there was any justification for embarking on speculation as to what the position might be when Mr Burke reaches the final stages of his life.

38. Turning to Mr Burke's concern that ANH may be withdrawn, contrary to his expressed wishes, so as to cause him to die of hunger and thirst while he is still competent, we have been unable to follow Munby J's reasoning and fear that he may have lost the wood for the trees. In particular, we have not been able to follow his reason for concluding that Articles 3 and 8 of the Convention would be infringed, but not Article 2. Munby J considered a body of authority that establishes that Article 2 will not be violated when death follows withdrawal of treatment that has been rejected by the patient, in exercise of his right of self-determination, or because withdrawal of treatment was considered in the best interests of an incompetent patient for whom life offered intolerable suffering. He concluded:

> "162. … Article 2 does not entitle anyone to continue with life-prolonging treatment where to do so would expose the patient to "inhuman or degrading treatment" breaching Article 3. On the other hand, a withdrawal of life-prolonging treatment which satisfies the exacting requirements of the common law, including a proper application of the intolerability test, and in a manner which is in all other respects compatible with the patient's rights under Article 3 and Article 8 will not, in my judgment, give rise to any breach of Article 2."

39. We endorse this conclusion. It does not, however, lead to the further conclusion that if a National Health doctor were deliberately to bring about the death of a competent patient by withdrawing life-prolonging treatment contrary to that patient's wishes, Article 2 would not be infringed. It seems to us that such conduct would plainly violate Article 2. Furthermore, if English law permitted such conduct, this would also violate this country's positive obligation to enforce Article 2. As we have already indicated, we do not consider that English criminal law would countenance such conduct. However, the fact that Articles 2, 3 and 8 of the Convention may be engaged does not, in our judgment, advance the argument or alter the common law. We return to this point in our consideration of Declaration 6, and the judge's reliance on the decision of Coleridge J in *D v NHS Trust (Medical Treatment: Consent: Termination)* [2003] EWHC (Fam) 2793; [2004] 1 LR and of the ECtHR in *Glass v UK* (2004) 1 FLR 1019.

The doctor with care of Mr Burke must either comply with his wish to be given ANH or arrange for another doctor to do so

40. For the reasons that we have given we consider that the doctor with care of Mr Burke would himself be obliged, so long as the treatment was prolonging Mr Burke's life, to provide ANH in accordance with his expressed wish. We do not believe that this has ever been open to doubt.

The lawfulness of paragraphs 13, 16, 32, 42 and 81 of the Guidance

41. At this stage we are concerned with what should have been considered to be the only relevant question in relation to the Guidance. Is it compatible with the duty of a doctor to administer ANH to a competent patient where this is necessary to keep the patient alive and the patient expresses a wish to be kept alive?

Paragraph 13

42. This paragraph deals only with the right to refuse treatment. It has no relevance to the duty of a doctor to provide ANH in order to keep a patient alive. We cannot see that it has any bearing on the issues before us. That said, it seems to us that this paragraph reflects the law.

Paragraph 16

43. We cannot see what relevance this has to the provision of ANH, save perhaps in its bearing on what the position would be if a patient demanded that ANH be administered or continued in the terminal stages of an illness where it was not going to prolong life. This is an unlikely scenario and not one that can properly concern Mr Burke at this stage of his illness.

Paragraph 32

44. This is part of the general framework of the guidance and not specifically directed to the provision, or withdrawal, of ANH. We accept that, if read in isolation, the phrase "taking account of the views of the patient" might suggest that a consultant or general practitioner in charge of a patient's care could withhold or withdraw ANH contrary to the expressed wish of a competent patient if he considered that there was good reason for disregarding that wish. Taken in the context of the Guidance as a whole, however, we do not consider that any reasonable doctor would conclude from paragraph 32 that it would be permissible to withdraw life-prolonging treatment with a view to ending a patient's life despite the patient's expressed wish to be kept alive.

Paragraph 42

45. We understand that it is the second half of this paragraph that the judge considered objectionable. This could only be relevant to Mr Burke's predicament if one postulates that a doctor might consider it 'clinically inappropriate' to keep him alive by administering ANH despite his wishes that this should be done. We consider such a scenario to be totally unrealistic.

Paragraph 81

46. This is the only paragraph to which the judge has taken exception that deals expressly with ANH. The first sentence requires the doctor to comply with the expressed wishes of a patient with capacity. No exception can be taken to this. The remainder deals with the approach to be taken where the patients lack capacity to decide for themselves and their wishes cannot be determined. We cannot see that this has any relevance to Mr Burke's predicament.

47. For these reasons, we do not consider that, insofar as the Guidance relates to Mr Burke's predicament, there was any ground for declaring it unlawful.

Concerns about the wider implications of Munby J's judgment

48. We have identified the following topics explored by Munby J in his judgment in passages which have given rise to concern because of apparent implications which extend beyond the predicament of Mr Burke:

i) The right of a patient to select the treatment that he will receive;

ii) The circumstances in which life-prolonging treatment can be withdrawn from a patient who is incompetent;

iii) The duty to seek the approval of the court before withdrawing life-prolonging treatment.

The right of a patient to select the treatment that he will receive

49. Munby J identifies that the duty to care for a patient involves the duty to provide the treatment that is in the patient's best interests, referring to a statement by Lord Brandon of Oakbrook in *In Re F (Mental patient: sterilisation)* [1990] AC 1 at p. 56, a passage dealing with the duty owed to an incompetent patient. Munby J then identifies that what is in the best interests of a patient depends upon the wishes of the patient, which may be influenced by matters which go beyond wanting to be cured, to continue to live or to avoid pain and suffering – all matters which the doctor might otherwise consider to be in the patient's best interest. He then postulates that it is the duty of the doctor to provide that treatment which complies with the wishes of the patient. At one point he states (paragraph 99):

> "If the patient is competent (or, although incompetent, has made an advance directive which is both valid and relevant to the treatment in question) there is no difficulty in principle: the patient decides what is in his best interests and what treatment he should or should not have."

50. The GMC is concerned that these passages suggest that a doctor is obliged, if the patient so requires, to provide treatment to a patient, or to procure another doctor to provide such treatment, even though the doctor believes that the treatment is not clinically indicated. No such general proposition should be deduced from Munby J's judgment, nor do we believe that he intended to advance any such general proposition. So far as the general position is concerned, we would endorse the following simple propositions advanced by the GMC:

i) The doctor, exercising his professional clinical judgment, decides what treatment options are clinically indicated (i.e. will provide overall clinical benefit) for his patient.

ii) He then offers those treatment options to the patient in the course of which he explains to him/her the risks, benefits, side effects, etc involved in each of the treatment options.

iii) The patient then decides whether he wishes to accept any of those treatment options and, if so, which one. In the vast majority of cases he will, of course, decide which treatment option he considers to be in his best interests and, in doing so, he will or may take into account other, non clinical, factors. However, he can, if he wishes, decide to accept (or refuse) the treatment option on the basis of reasons which are irrational or for no reasons at all.

iv) If he chooses one of the treatment options offered to him, the doctor will then proceed to provide it.

v) If, however, he refuses all of the treatment options offered to him and instead informs the doctor that he wants a form of treatment which the doctor has not offered him, the doctor will, no doubt, discuss that form of treatment with him (assuming that it is a form of treatment known to him) but if the doctor concludes that this treatment is not clinically indicated he is not required (i.e. he is under no legal obligation) to provide it to the patient although he should offer to arrange a second opinion.

51. The relationship between doctor and patient usually begins with diagnosis and advice. The doctor will describe the treatment that he recommends or, if there are a number of alternative treatments that he would be prepared to administer in the interests of the patient, the choices available, their implications and his recommended option. In such circumstances the right to refuse a proposed treatment gives the patient what appears to be a positive option to choose an alternative. In truth the right to choose is no more than a reflection of the fact that it is the doctor's duty to provide a treatment that he considers to be in the interests of the patient and that the patient is prepared to accept.

52. Munby J was not, however, concerned with the extent to which, in general, a patient has a right to insist on a particular treatment. He was concerned with the choice of whether or not to receive life-prolonging treatment and the right to decide "how one chooses to pass the closing days and moments of one's life and how one manages one's death" (judgment paragraph 63). The passages of general discussion in his judgment must be read in this context.

53. We have indicated that, where a competent patient indicates his or her wish to be kept alive by the provision of ANH any doctor who deliberately brings that patient's life to an end by discontinuing the supply of ANH will not merely be in breach of duty but guilty of murder. Where life depends upon the continued provision of ANH there can be no question of the supply of ANH not being clinically indicated unless a clinical decision has been taken that the life in question should come to an end. That is not a decision that can lawfully be taken in the case of a competent patient who expresses the wish to remain alive.

54. There is one situation where the provision of ANH will not be clinically indicated that is not relevant to Mr Burke's concern but which received a disproportionate amount of attention in this case. In the last stage of life the provision of ANH not only may not prolong life, but may even hasten death. Unchallenged evidence from Professor Higginson illustrated the latter proposition. At this stage, whether to administer ANH will be a clinical decision which is likely to turn on whether or not it has a palliative effect or is likely to produce adverse reactions. It is only in this situation that, assuming the patient remains competent, a patient's expressed wish that ANH be continued might conflict with the doctor's view that this is not clinically indicated.

55. As we understand Munby J's judgment, he considered that in this situation the patient's wish to receive ANH must be determinative. We do not agree. Clearly the doctor would need to have regard to any distress that might be caused as a result of overriding the expressed wish of the patient. Ultimately, however, a patient cannot demand that a doctor administer a treatment which the doctor considers is adverse to

the patient's clinical needs. This said, we consider that the scenario that we have just described is extremely unlikely to arise in practice.

The position of the incompetent patient

56. A large part of Munby J's judgment and the submissions placed before us related to the position of the incompetent patient. Three situations were discussed: (1) the patient in a PVS; (ii) the incompetent but sentient patient capable of being kept alive for an indefinite period by the provision of ANH; (iii) the patient in the final stages of life. We would reiterate that Mr Burke's legitimate concern at this stage of his life does not relate to any of these situations.

57. The situation of a patient in a PVS was only referred to in passing. It fell, however, within the compass of Mr Gordon's general submission that, if the patient has made an advance directive that he is to be kept alive, this must be complied with as a matter of law. The position of a patient in a PVS was addressed at length by the House of Lords in *Bland* and we do not consider it appropriate in this case to add to what was said by their Lordships, other than to make the following observation. While a number of their Lordships indicated that an advance directive that the patient should not be kept alive in a PVS should be respected, we do not read that decision as requiring such a patient to be kept alive simply because he has made an advance directive to that effect. Such a proposition would not be compatible with the provisions of the Mental Capacity Act 2005, which we consider accords with the position at common law. While section 26 of that Act requires compliance with a valid advance directive to refuse treatment, section 4 does no more than require this to be taken into consideration when considering what is in the best interests of a patient.

58. There are tragic cases where treatment can prolong life for an indeterminate period, but only at a cost of great suffering while life continues. Such a case was *In re J (a Minor) (Wardship: Medical Treatment)* [1991] Fam 33. There are other cases, and these are much more common, where a patient has lost competence in the final stages of life and where ANH may prolong these final stages, but at an adverse cost so far as comfort and dignity are concerned, sometimes resulting in the patient's last days being spent in a hospital ward rather than at home, with family around.

59. It is to these situations that so much of the debate in this case has been directed. Apprehensions have been expressed by some who have intervened that those in charge of patients may too readily withdraw, or fail to provide, ANH or other life prolonging treatment on the ground that the patient's life, if prolonged, will not be worth living. As an example of the first situation described above, the Disability Rights Commission brought to our attention the disturbing story of Jane Campbell. She suffers from spinal muscular atrophy and is severely disabled. She was not expected to live beyond the age of four, but has lived a fulfilling and productive life of high achievement. In 2003 she was struck down by pneumonia. Two consultants were minded to conclude that her life was so parlous that, if she needed artificial respiration to remain alive she would not wish to receive it. Only the intervention of her husband, who showed them a photograph of her taking her degree, persuaded the consultants that her life was worth saving.

60. Turning to the other situation described above, disturbing case reports were placed by the Medical Ethics Alliance before the Joint Committee on the draft Mental

Incapacity Bill, and subsequently before us. These were cases where patients who were terminally ill appear to have been denied water and nutrition in circumstances where this was contrary to the demands of palliative care.

61. These reports did not constitute admissible evidence, but underlined the importance of clear law and guidance in this area. After a lengthy analysis of jurisprudence under the heading *'Best interests and life-prolonging treatment'* the judge set out a summary of his conclusions at paragraph 116, which included the following:

> "There is a very strong presumption in favour of taking all steps which will prolong life, and save in exceptional circumstances, or where the patient is dying, the best interests of the patient will normally require such steps to be taken. In case of doubt that doubt falls to be resolved in favour of the preservation of life. But the obligation is not absolute. Important as the sanctity of life is, it may have to take second place to human dignity. ***In the context of life-prolonging treatment the touchstone of best interests is intolerability. So if life-prolonging treatment is 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***. "

62. We do not think that any objection could have been taken to this summary had it not contained the final two sentences, which we have emphasised. The suggestion that the touchstone of 'best interests' is the 'intolerability' of continued life has, understandably given rise to concern. The test of whether it is in the best interests of the patient to provide or continue ANH must depend on the particular circumstances. The two situations that we have considered above are very different. As to the approach to be adopted in the former, this court dealt with that in *Re J* and we do not think that it is appropriate to review what the court there said in a context that is purely hypothetical.

63. As to the approach to best interests where a patient is close to death, it seems to us that the judge himself recognised that 'intolerability' was not the test of best interests. At paragraph 104 he said:

> "where the patient is dying, the goal may properly be to ease suffering and, where appropriate, to 'ease the passing' rather than to achieve a short prolongation of life."

We agree. We do not think it possible to attempt to define what is in the best interests of a patient by a single test, applicable in all circumstances. We would add that the disturbing cases referred to in paragraphs 57 and 58, if correctly reported, were cases where the doctors appear to have failed to observe the Guidance. They are not illustrative of any illegality in the Guidance. The Guidance expressly warns against treating the life of a disabled patient as being of less value than the life of a patient without disability, and rightly does so.

The Guidance

64. Is the Guidance defective? Munby J declared in declaration (5) that paragraphs 13, 16, 32 and 42 were unlawful in that they failed to recognise that the decision of a competent patient on whether ANH should be provided was determinative in principle of whether or not such treatment was in the patient's best interests. We have commented that equating best interests with the expressed wishes of a competent patient is unhelpful. The question to be asked in relation to these paragraphs is whether they indicate clearly, in their context, that a doctor cannot remove ANH that is keeping a competent patient alive when this is contrary to the wishes of the patient. Paragraphs 13 and 16 are general paragraphs, not specifically directed to ANH. They make it clear that a patient is legally entitled to *refuse* treatment and state that doctors must 'take account' of patients' preferences when providing treatment. Taken alone, they do not state in terms that a doctor cannot discontinue ANH contrary to the wishes of a competent patient, but we consider that this is their inference. The same is true of paragraphs 32 and 42. These suggest that the wishes of the patient should be respected unless this is 'clinically inappropriate' and, as we have said, administering treatment that is necessary to keep a patient alive cannot be described as 'clinically inappropriate'.

65. Paragraph 81 is in the section of the Guidance which deals expressly with ANH. It commences, "Where patients have capacity to decide for themselves, they may consent to, or refuse, any proposed intervention of this kind". We do not understand the criticism made by the judge in Declaration (4) that this "fails to recognise that the decision of a competent patient that ANH should be provided is determinative of the best interests of the patient", albeit that we deprecate equating a patient's wishes with his best interests.

66. Declaration (4) goes on to declare that paragraph 81 is unlawful because it does not make it clear that ANH can only be withdrawn from a patient who is not dying if his continued life would be intolerable. We do not consider that the terms of paragraph 81 are unlawful. We do, however, feel that the wording of that part of the paragraph which deals with the position where death is not imminent could be better drafted. We believe that it is attempting to spell out the circumstances in which it may be lawful to withdraw ANH in a case such as that of *Re J.* The statement that the provision of ANH "may cause suffering or be too burdensome in relation to the possible benefits" is not a clear or helpful description of the circumstances in which life is so burdensome that there is no duty to prolong it. This inadequacy of drafting does not, however, justify the judge's declaration.

Is there a legal requirement to obtain court authorisation before withdrawing ANH?

67. The judge's Declaration (6) suggests that "in certain circumstances" this question must be answered in the affirmative. What circumstances did the judge have in mind? The answer is given by paragraph 214(g) of his judgment:

> "(g) Where it is proposed to withhold or withdraw ANH the prior authorisation of the court is required as a matter of law (and thus ANH cannot be withheld or withdrawn without prior judicial authorisation): (i) where there is any doubt or

> disagreement as to the capacity (competence) of the patient; or (ii) where there is a lack of unanimity amongst the attending medical professionals as to either (1) the patient's condition or prognosis or (2) the patient's best interests or (3) the likely outcome of ANH being either withheld or withdrawn or (4) otherwise as to whether or not ANH should be withheld or withdrawn; or (iii) where there is evidence that the patient when competent would have wanted ANH to continue in the relevant circumstances; or (iv) where there is evidence that the patient (even if a child or incompetent) resists or disputes the proposed withdrawal of ANH; or (v) where persons having a reasonable claim to have their views or evidence taken into account (such as parents or close relatives, partners, close friends, long-term carers) assert that withdrawal of ANH is contrary to the patient's wishes or not in the patient's best interests."

68. We would observe that even if this paragraph accurately states the law, it does not follow that the Guidance is illegal in that it directs the doctor concerned to seek legal advice rather than to seek the authority of the court to the withdrawal of ANH. On the contrary, even if the judge is correct about the legal duty, we consider that paragraphs 38 and 82 of the Guidance are proper and lawful. We note that the judge inaccurately summarises the effect of those paragraphs by saying that they direct the doctor to consult a clinician ***or*** take legal advice, when what in fact they direct is that the doctor should do both.

69. Declaration (6) has caused considerable concern. The Intensive Care Society informed us that each year approximately 50,000 patients are admitted to intensive care units and of these 30% die in the unit or on the wards before hospital discharge. Most of these die because treatment is withdrawn or limited, albeit in circumstances where the clinicians conclude that such treatment would be likely merely to prolong the process of dying. There is not always agreement on the part of all concerned as to the withdrawal of treatment. This is hardly surprising. Grief stricken relatives may not be able to accept that the patient is beyond saving. The ICS calculates that, if Munby J's criteria were applied, approximately 10 applications a day would have to be made to the courts.

70. In the event, we do not consider that the judge is right to postulate that there is a legal duty to obtain court approval to the withdrawal of ANH in the circumstances that he identifies.

71. We asked Mr Gordon to explain the nature of the duty to seek the authorisation of the court and he was not able to give us a coherent explanation. So far as the criminal law is concerned, the court has no power to authorise that which would otherwise be unlawful – see, for instance, the observation of Lord Goff of Chievely in *Bland* at p. 785 H. Nor can the court render unlawful that which would otherwise be lawful. The same is true in relation to a possible infringement of civil law. In *Bland* the House of Lords recommended that, *as a matter of good practice*, reference should be made to the Family Court before withdrawing ANH from a patient in a PVS, until a body of experience and practice had built up. Plainly there will be occasions in which it will be advisable for a doctor to seek the court's approval before withdrawing ANH in

other circumstances, but what justification is there for postulating that he will be under a legal duty so to do?

72. The judge's reasoning appears in paragraphs 195 to 211 of his judgment. His starting point was the identification by the courts of a special category of cases where medical procedures required the sanction of the court, even if all concerned were agreed that the procedures were desirable. He observed that initially the requirement to obtain prior judicial sanction "was not a matter of law but rather of good practice".

73. The judge then observed that more recently the courts had identified a further category of important decisions where the requirement for judicial intervention arose 'if there is disagreement between those concerned'. He cited at length from the decision of Coleridge J in *D v NHS Trust (Medical Treatment: Consent: Termination)* [2003] EWHC (Fam) 2793; [2004] 1 LR 1110. That was a case where the treatment under consideration was the termination of the pregnancy of an incompetent adult. Coleridge J identified a number of circumstances where, because the legitimacy of such treatment was open to doubt, it was 'necessary' to seek the authorisation of the court.

74. We do not read Coleridge J's judgment as purporting to transform the requirement to seek the approval of the court from a matter of good practice into a legal requirement. He did, however, observe at paragraph 31:

> "The advent of the Human Rights Act 1998 has enhanced the responsibility of the court to positively protect the welfare of these patients and, in particular, to protect the patient's right to respect for her private and family life under Art 8(1) of the European Convention… ."

75. Munby J emphasised this passage, before turning to consider the implications of decisions of the ECtHR first on admissibility and subsequently on the merits in *Glass v UK* (2004) 1 FLR 1019; [2004] Lloyds Rep Med 76. He concluded that the latter decision converted what had previously been only "a matter of good practice" into "a matter of legal requirement" by reason of the Human Rights Act 1998 (judgment paragraph 210). He observed that this was 'a significant and potentially very important change'. If the judge was correct we would concur. Accordingly it is necessary to consider *Glass* with some care.

76. The application in *Glass* was brought by a mother on behalf of her small child. The complaint related to the treatment of the child when in hospital. The doctors thought that the child was dying and administered diamorphine by way of palliative despite the objections of the mother, who thought that the intention of this treatment was to hasten the child's death. The disagreement culminated in a fight in the hospital and the removal of the child by the mother. The child recovered. The mother also complained that the doctors had imposed a 'do not resuscitate' direction in relation to the child without her consent, but the ECtHR did not give separate consideration to this complaint. They treated the case as one of the imposition of invasive treatment on a child contrary to the wishes of its parent.

77. The ECtHR gave detailed consideration to the position under English law, as this was presented to the court. The ECtHR understood the position to be as follows. As a

general proposition, medical treatment of a child requires the authorisation of the child's parents. Where the parents do not consent, the court can authorise such treatment. The doctors can, however, lawfully impose treatment without the consent of the parents or the authorisation of the court in a situation of emergency. The ECtHR summarised the position as follows: at paragraph 75:

> "the regulatory framework in the respondent State is firmly predicated on the duty to preserve the life of a patient, save in exceptional circumstances. Secondly, that same framework prioritises the requirement of parental consent and, save in emergency situations, requires doctors to seek the intervention of the courts in the event of parental objection."

78. In these circumstances the ECtHR identified the critical issue as whether the child's treatment had been administered in circumstances of emergency which justified the failure on the part of the hospital to seek the approval of the court. It commented in paragraph 76:

> "For the court, the applicants' contention in reality amounts to an assertion that, in their case, the dispute between them and the hospital staff should have been referred to the courts and that the doctors treating the first applicant wrongly considered that they were faced with an emergency. However, the Government firmly maintain that the exigencies of the situation were such that diamorphine had to be administered to the first applicant as a matter of urgency in order to relieve his distress and that it would not have been practical in the circumstances to seek the approval of the court. However, for the court, these are matters which fall to be dealt with under the 'necessity' requirement of Art 8(2), and not from the standpoint of the 'in accordance with the law' requirements."

79. After considering the facts, the ECtHR concluded that the mother had not consented to the administration to her child of diamorphine and that, when this became apparent to the doctors, they had ample time to get the court to resolve the position. They held in paragraph 83:

> "The court considers that, having regard to the circumstances of the case, the decision of the authorities to override the second applicant's objection to the proposed treatment in the absence of authorisation by a court resulted in a breach of Art 8 of the Convention"

80. This was not a decision which made "a significant and potentially very important change in English law". The ECtHR did no more than consider the implications of the doctors' conduct in the light of what the ECtHR understood to be English law. The true position is that the court does not "authorise" treatment that would otherwise be unlawful. The court makes a declaration as to whether or not proposed treatment, or the withdrawal of treatment, will be lawful. Good practice may require medical practitioners to seek such a declaration where the legality of proposed treatment is in

doubt. This is not, however, something that they are required to do as a matter of law. For these reasons Declaration 6 made by Munby J misstated the law.

81. For all these reasons this appeal is allowed and the declarations made by Munby J set aside.

Footnote

82. We have referred to matters put before us by three interveners: the Disability Rights Commission; the Medical Ethics Alliance and the Intensive Care Society. We mean no discourtesy to the other interveners when we observe that a great deal of their thoughtful and well-presented contributions falls victim to our general view that this litigation expanded inappropriately to deal with issues which, whilst important, were not appropriately justiciable on the facts of the case. In so far as the interveners directly addressed the issues which we have addressed in this judgment, we hope that our conclusions are clear.

83. We wish to end by emphasising one point, having particular regard to the evidence of Jane Campbell. It is in our view of the utmost importance that the Guidance should be understood and implemented at every level throughout the National Health Service and throughout the medical profession. People in the unhappy position of Mr Burke and Mrs Campbell are entitled to have confidence that they will be treated properly and in accordance with good practice, and that they will not be ignored or patronised because of their disability. Having produced the Guidance, the task of the GMC, it seems to us, is to ensure that it is vigorously promulgated, taught, understood and implemented at every level and in every hospital. If the extensive interest generated in this case helps achieve that objective, the proceedings will have served a useful purpose.