IN THE COURT OF APPEAL
ON APPEAL FROM THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

(The Hon. Mr Justice Munby)

B E T W E E N :

GENERAL MEDICAL COUNCIL

Appellant

- and -

OLIVER LESLIE BURKE

THE DISABILITY RIGHTS COMMISSION

THE OFFICIAL SOLICITOR TO THE SUPREME COURT

Respondents

GROUNDS OF APPEAL
FOR INSERTION AT
SECTION 7 OF APPELLANT'S NOTICE

The Appellant appeals the order at section 5 because:

1. The Learned Judge erred in concluding at paragraphs 116(11) (generally) and 214(b) (in relation to artificial nutrition or hydration ("ANH")) that if a patient is competent (or, although incompetent, has made an advance directive which is both valid and relevant to the treatment in question), his decision to require the provision of ANH which the patient believes is necessary to protect him from what he sees as acute mental and physical suffering is in principle determinative. A patient does not have a right to require the provision of a particular form of treatment. Although it is for a competent patient to assess the benefits and burdens of a particular treatment for

himself, (and ultimately to choose what treatment, if any, to accept), the final judgment as to what medical treatment(s) it is appropriate to offer is for a doctor to make, taking into account, not only what he considers clinically to be in the best interests of the patient (and this will involve taking into account the patient's concerns, values and preferences) but also, inter alia, his duty of care to offer (only) treatments which are *Bolam* compliant, considerations of efficacy, potential complications, ethical and moral issues, occasionally resources, and the vital consideration of the patient's assessment of his own best interests. Such considerations cannot be excluded from the picture as the Learned Judge wrongly suggested at paragraphs 27 - 29 of his judgment. To give to a patient the right to require treatment of a particular form could also result in doctors (or Trusts) being legally required to provide treatment which in their view would not be in or would be contrary to that patient's best interests.

2. The Learned Judge erred in concluding at paragraphs 214(c) and 214(e) that the withdrawal of ANH from a patient at any stage before the patient finally lapses into a coma would expose the patient to acute mental and physical suffering. That finding was contrary to the evidence. In particular:

   a) The evidence of Dr David Westaby, Consultant Physician and Gastroenterologist, and Head of Gastroenterology at Chelsea and Westminster Hospital, recorded at paragraph 20 of the Judgment, was to the effect that:

      i) It is quite incorrect to consider the maintenance of ANH as, at worst, a neutral option. The treatment may be associated with complications, infection and adverse psychological effects;

      ii) In his own practice, the majority of cases in which ANH is withheld were patients with progressive dementia. In such cases, it is common for oral intake of fluids and nutrients to be diminished or absent, commonly with no hunger or thirst exhibited, and no overt distress displayed.

   b) The evidence of Professor Irene Higginson, Professor of Palliative Care and Policy at Guy's, King's and St Thomas' School of Medicine, was to similar effect,

and made it clear that whenever ANH was withheld or withdrawn, symptom management should always be provided to alleviate suffering. In particular, she explained that a reduction in appetite is a normal part of the dying process for many patients and how the provision of artificial nutrition may, for example in a patient with cancer, increase the patient's metabolic rate with the result that the patient actually loses weight (this evidence was set out in paragraph 19 of the judgment but not referred to by the Learned Judge again).

3. The Judge's understanding of the facts was erroneous in the following further respects:

(1) ANH is not necessarily, as he held at paragraph 27 of his judgment, a "relatively simple and straightforward" form of treatment. On the contrary:

(a) The decision whether or not to provide artificial hydration and/or artificial nutrition may well involve a difficult balancing of the many and various factors for and against the provision of such treatment (see paragraphs 8 and 9 of the statement of Professor Higginson: the Learned Judge cited only part of the relevant passages of her statement in his judgment);

(b) There are a number of well recognised risks (for example, the risk of infection) and complications (for example, in relation to the placement of naso gastric and gastrotomy tubes) involved in the provision of both artificial nutrition and artificial hydration. These were explained and set out by Dr Westaby in his statement in a passage cited by the Judge in paragraph 20 of his judgment.

(2) Contrary to the Judge's assumption to the contrary effect (see paragraphs 27 and 29 of his judgment), issues as to costs and resources may well be raised by the provision of ANH. For example, if ANH is provided (as is often the case) in an Intensive Care Unit the nursing and care costs associated with providing such treatment may be significant and the total

costs will be very significant if treatment is provided over any appreciable period of time. If ANH must now be provided much more widely than hitherto, the overall costs of doing so may also be significant.

(3) Contrary to the Judge's assumption, the provision of artificial nutrition cannot necessarily be equated for present purposes with the provision of artificial hydration. As Professor Higginson points out (at paragraph 11 of her statement) the decision-making process is very different and it is not necessarily the case that where a patient requires one form of treatment he/she should receive the other. Moreover, the provision of artificial nutrition is or may be significantly more complex than the provision of artificial hydration.

4. The Learned Judge's approach, as set out in paragraphs 27 – 29 of the judgment, whereby he sought to categorise cases as falling within or without certain categories (for example, meeting the *Bolam* test) was much too simplistic. Treatments cannot be categorised in this way in the abstract. On the contrary, whether a treatment falls within or without these (or any other) categories can only be assessed by reference to the particular patient taking into account all the circumstances of his "*case*". Further, it is far from clear how or when a "*case*" could be said to fall within or without these categories or who should so decide.

5. The Learned Judge accordingly erred at paragraph 214(e) in concluding that he found it hard to envisage any circumstances, other, perhaps, than those envisaged by Professor Higginson, in which a withdrawal of ANH from a sentient patient whether competent or incompetent could be compatible with the European Convention on Human Rights.

6. The Learned Judge's conclusion at paragraph 214(f) that ANH could be withdrawn once the patient had entered a final coma was inconsistent with his reasoning, at paragraphs 213(m) and (n), that the patient's advance directive as to what life-prolonging treatment he should have was in principle determinative. Further, the legal distinction which he drew between a patient who has not (yet) lapsed into a

coma and a patient who has done so (see paragraphs 170 - 176) lacks any logical, sensible or coherent rationale.

7. The Learned Judge erred at paragraphs 213(o) and 214(d) in concluding that if a treatment was providing some benefit to an incompetent but sentient patient it should be continued unless the patient's life thus prolonged would be from his point of view "intolerable". The Learned Judge ought to have found that in the case of an incompetent patient who had not made a valid or relevant advance directive, it was for the treating doctor to reach a consensus with the medical team, and those close to the patient, on what treatment would be in the best interests of the patient, seen from the patient's point of view, and taking into account all the benefits and burdens associated with the treatment, and the patient's known wishes and, in the absence of a consensus, to apply to the court. The test of intolerability is both too narrow and subjective. The correct test is best interests.

8. The consequences of the judgment in the case of an incompetent patient who has not made a valid advance directive and who has not (yet) lapsed into a coma will or are likely to be that doctors either will feel impelled to provide or continue to provide treatment to such a patient notwithstanding that, having taken into account the known views and preferences, if any, of the patient, it is in the view of the doctors not in the best interests of the patient to do so or will feel impelled in every such case where they propose not to provide or to withdraw such treatment to apply to the court before doing so. Such an outcome would be wrong in principle and would impose an unnecessary and costly burden on both the doctors (or rather the Trusts who employ them) and the courts. Such a conclusion also ignores the evidence of Professor Higginson (to which the Learned Judge did not refer) that as a result many more patients would need to die in hospital notwithstanding that it is known that the majority of patients who have a poor prognosis wish to die at home (see paragraph 18 of her statement). Such an outcome also demonstrates the inappropriateness of the test of "*intolerability*" (see paragraph 7 above) since such a test would not be sensitive to the wishes of such patients (unlike the test of best interests) since the provision of ANH in such circumstances would be most unlikely

to satisfy the test of intolerability and there would be no valid advance directive refusing it.

9. The Learned Judge erred at paragraph 214(g) in enumerating the circumstances in which he concluded that the prior authorisation of the court was required as a matter of law before ANH could be withheld or withdrawn. In particular:

   a) it is not for the court to resolve disagreements about the diagnosis or prognosis for a particular patient;

   b) it is unclear who the Judge intended to include in the phrase "attending medical professionals".

10. It is unclear how widely the judgment applies:

   (1) Although:

      (a) In paragraph 27 of his judgment the Learned Judge stated that this was not a case about the prioritisation or allocation of resources, whether human, medical or financial, and that nothing he said should be treated as necessarily having any application in a case where resources are an issue;

      (b) In paragraph 28 the Learned Judge stated that this case was not about innovative, experimental or untested forms of treatment; and

      (c) In paragraph 29 he stated that this case was about a form of treatment (ANH) which is relatively simple and straightforward and which clearly meets the *Bolam* test,

      the Learned Judge went on to set out detailed conclusions as to what he held or must necessarily be assumed to have regarded as the relevant principles (see paragraphs 116, 178 and 213 of his judgment) without qualification or restriction or limitation. He

then applied those principles to the present case. The upshot is that it is quite unclear, notwithstanding paragraphs 27-29 of his judgment, how far and how widely his conclusions as to the principles as set out in the paragraphs referred to above apply to the provision of treatment other than ANH.

11. It is unclear what would be the obligations of the doctor (or Trust) in the case of an incompetent patient who had made an advance directive if the treatment which he specified in the directive met the *Bolam* test at the time the directive was made but no longer did so by the time that he became incompetent.