General Medical Council

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Annex: Relevant Case Law since 2002 – a summary

An NHS Trust v MB [2006] EWHC 507 (Fam)

Withdrawal of treatment - child
Disagreement between family and clinicians

- Life-supporting ventilation should not be withdrawn, on the grounds that prolongation of life was not the only relevant criteria for determining when and whether to withhold or withdraw treatment.
- "Others may analyse this judgment for its "implications". It is not a "policy based" judgment at all and is not designed to have "implications" (although I fully appreciate that it may do so)."
- http://livelink/edrms/llisapi.dll/fetch/2000/19874/107513/107516/5584699/5585341/Dilemmas_in_the_medical_treatment_of_patients_facing_inevitable_death.pdf?nodeid=7060549&vernum=0 The judge did not agree with medical opinion and did not grant a declaration that it would be lawful to withdraw LPT. However, the judge acknowledged that he could not require a doctor to act against their conscience about what it is clinically appropriate to do. This article analyses [potential] implications of this decision.

http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWHC/Fam/2006/507.html&query=Baby+and+MB&method=boolean

Burke v GMC [2005] EWCA Civ 1003

- If ANH is not clinically indicated, then there is no duty to provide it, even if a patient who has capacity requests it.
- Intolerability would not always be the test of best interests: it's not possible to define what would be in a patient's best interests by a single test, applicable in all the circumstances.

http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWCA/Civ/2005/1003.html&query="artificial+nutrition+and+hydration"&method=boolean

Wyatt & Anor v Portsmouth Hospital NHS & Anor [2005] EWCA Civ 1181 (12 October 2005)

Withholding treatment - Child
Disagreement between family and clinicians

- It was inappropriate to focus solely on whether or not a child's life would be intolerable if treatment were continued. Rather a broader approach to best interests should be taken.
- There is a strong presumption in favour of a course of action which will prolong life, but that presumption is not irrebuttable (Re J). The term "best interests" encompasses medical, emotional and all other welfare issues

http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWCA/Civ/2005/1181.html&query=title+(+wyatt+)&method=boolean

NHS Trust v. Ms D (2005) EWHC 2439 (Fam)

Withdrawal of treatment (PEG tube) – Adult who lacks capacity

- Best interests may be determined as meaning that 'a patient should not be subjected to more [treatment] than the minimum necessary to allow her to die peacefully and with dignity'

- The first question I ask myself is; "Are there any advantages to this patient in this condition in attempting by the use of artificial and very invasive procedures to prolong her survival beyond that which will naturally occur?" I can honestly answer that question by saying that I can think of none.

http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWHC/Fam/2005/2439.html&query=title+(+NHS+)&method=boolean

W Healthcare NHS Trust v H [2005] 1 WLR 834

Validity of an advance statement

- The case dealt with advance statements made many years earlier by KH, a 59-year-old woman who was suffering from multiple sclerosis. KH had made statements about medical treatment that she did not want, including one statement refusing life support machines and other statements refusing treatment, if she could not continue with a 'reasonable quality of life'.

- None of KH's statements had specifically addressed the issue of artificial nutrition and hydration. The court accepted that some of her statements may

have been sufficient to refuse other medical treatment, for example her desire not to be kept alive on 'life support machines'. However, the other remaining general statements, refusing treatment based on quality of life considerations, were insufficiently clear to amount to an advance directive and the court held that she had not refused the artificial nutrition and hydration

Glass v. the United Kingdom (ECHR, 2004).

- The administration of diamorphine to a minor, against the wishes of his legal proxy, interfered with his Article 8(1) rights to respect for his private life, in particular his right to "physical integrity".
- The failure to seek Court authorisation, in a case where clinicians and a child's family were in fundamental disagreement over the child's treatment, breached the child's Article 8 rights.

http://www.bailii.org/cgi-bin/markup.cgi?doc=/eu/cases/ECHR/2004/103.html&query=resuscitation&method=boolean

An NHS Trust v S & Ors [2003] EWHC 365 (Fam)

Non-discrimination

- "The Hospital Trust has, very properly, made it clear that it has always recognised the right of S to be treated as fairly as any other patient without his disabilities. I have no doubt that the Hospital Trust wishes to do the best it can for S and has tried to put his best interests in the forefront of its planning. But the approach of the medical and nursing team, both in the paediatric unit and in the adult unit, has been coloured by their real difficulties in the lack of verbal communication with S and their vivid recollections of how difficult he was to manage in the hospital after he was admitted for emergency lifesaving treatment in May 2000. I have the feeling that those difficulties may have had a disproportionate effect upon their approach to future treatment for S."

- "In my judgment, a kidney transplant ought not to be rejected on the grounds of his inability to understand the purpose and consequences of the operation or concerns about his management."

http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWHC/Fam/2003/365.html&query=title+(+nhs+)&method=boolean

Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam)

Refusal of treatment by adult with capacity

- If mental capacity is not in issue and the patient, having been given the relevant information and offered the available options, chooses to refuse the treatment, that decision has to be respected by the doctors. Considerations that the best interests of the patient would indicate that the decision should be to consent to treatment are irrelevant.

- If there is no disagreement about competence, but the doctors are for any reason unable to carry out the wishes of the patient, their duty is to find other doctors who will do so.

- The treating clinicians and the hospital should always have in mind that a seriously physically disabled patient who is mentally competent has the same right to personal autonomy and to make decisions as any other person with mental capacity.

http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWHC/Fam/2002/429.html&query=title+(+ms+)+and+title+(+b+)&method=boolean

Below follows a summary of relevant developments in statute law

Developments in statute law since 2002

Mental Capacity Act 2005

The Mental Capacity Act 2005 creates a new legal framework (for England & Wales) which allows adults with decision-making capacity to appoint someone else to make decisions about life-prolonging treatments on their behalf when they become incapacitated. It gives statutory force to written advance refusals of life-prolonging treatments (provided they meet certain criteria). These provisions came into force from October 2007. There are also provisions requiring the appointment of an Independent Mental Capacity Advocate (from April 2007 in England and October 2007 in Wales) for incapacitated adults who have no-one appropriate to consult, when decisions have to be made about serious medical treatments (such as life-prolonging interventions). These changes must be reflected in updated GMC guidance.

Adults with Incapacity (Scotland) Act 2000

The provisions of the Act which govern health and social care decisions came into force in 2001. The Code of Practice provides some guidance about how to approach decisions about providing life-prolonging treatments.

The Act makes clear that an individual's wishes and feelings, including in relation to refusals of life-prolonging treatments, *should be* rather than *must be* taken into account. The Code discusses factors to consider in establishing the validity, applicability and continuing relevance of an advance refusal of treatment. Although not specifically stated, the implication is that an advance refusal of a life-prolonging treatment could be a decisive factor in the final decision about whether that treatment was offered or continued. Advice from the Scottish Government is that a doctor who decided not to follow the wishes expressed in an advance refusal of treatment would need to be able to provide good reasons to support that decision.

Welfare attorneys and welfare guardians can not make decisions about withdrawing or withholding life-prolonging treatments. They can offer a view about the wishes of the patient and doctors must take this into account in reaching a decision about the patient's interests. If there was disagreement between an attorney or guardian and the doctor, the MWC could step in to try to resolve the issue. If that wasn't possible, then the case could be referred to the High Court.

Over the past 2 years, the GMC has received a number of inquiries from clinicians and patient support groups who have experienced confusion in understanding and working with these aspects of the Act and Code. Our discussions suggest that they might benefit from additional guidance in these areas. It is not clear whether it would be most appropriate for the GMC, the MWC or some other body, to provide this advice.

Mental Health (Care and Treatment) Scotland Act 2003

There have also been developments under this Act, which have implications for end of life decision-making that could not have been anticipated at the time the GMC booklet was produced.

Guidance notes have been issued by the Mental Welfare Commission clarifying the extent to which it might be acceptable for healthcare professionals to override an adult's advance refusal of life-saving treatment for a mental disorder, and clarifying the legal basis for providing artificial nutrition against a patient's wishes when it is being regarded as life-saving treatment. The GMC received a number of informal inquiries about whether we considered the guidance to be consistent with the WHWD guidance. Work to update GMC guidance may raise these questions again.

Human Tissue Act 2004, Human Tissue (Scotland) Act 2006

The Human Tissue Acts (England and Wales and Northern Ireland; Scotland) came into force in September 2006. We had not intended to produce any guidance on matters covered by these laws, since doctors must comply with the Codes of Practice and regulations which set out the framework for making decisions, including advice about consent.

However, there are a number of issues which are being seen as barriers to increasing the supply of organs for transplant. Some of the difficulties appear to lie in the legislation itself; in as much as they relate to questions about valid consent, and about continuing with treatment and testing potential donors after a decision has been taken that further treatment will give no benefit to the patient. There is some interest in the GMC providing advice, to reinforce messages about doctors considering and raising the possibility of organ donation, where decisions have been made to withhold or withdraw life-prolonging treatments. We would need to look into this further with UK Transplant and other interest groups.

Summary

The WG would need to consider to what extent the implications of these legal developments should be addressed in revised guidance on end of life decision making.