IN THE COURT OF APPEAL **2004/2086**
ON APPEAL FROM HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISIONS
ADMINISTRATIVE COURT **CO/4038/2003**

MUNBY J [2004] EWHC 1879 (Admin)

BETWEEN:

THE GENERAL MEDICAL COUNCIL

Appellant

– and –

OLIVER LESLIE BURKE

Respondent

– and –

THE OFFICIAL SOLICITOR

Interested Party

– and –

THE DISABILITY RIGHTS COMMISSION

Interested Party

– and –

THE CATHOLIC BISHOPS CONFERENCE OF ENGLAND AND WALES

Intervener

– and –

THE SECRETARY OF STATE FOR HEALTH

Intervener

– and –

PATIENT CONCERN

Intervener

INTERVENTION OF THE CATHOLIC BISHOPS' CONFERENCE OF ENGLAND AND WALES (FOR HEARING 16-19 MAY 2005)

Introduction

1. These submissions arise out of the responsibilities and experience of the bishops who are members of the Catholic Bishops' Conference of England

and Wales ("CBCEW"). Their responsibilities include (1) communicating to Roman Catholics, and as far as appropriate to everyone, ideas of human dignity and equality, and of the human rights and responsibilities with which the laws of our country are concerned; (2) sharing with other pastoral ministers in attending to some of the important needs of persons who are ill, often in the extremities of illness or injury, and of the dying, and (3) close involvement in many institutions maintained for the purpose of giving every kind of assistance to the sick, the disabled, and other dependent and vulnerable members of society, whatever their beliefs.

2. The moral standards and analyses articulated in this intervention are not, however, those of a "Catholic morality". Rather, they belong to the common moral tradition that is shared by people of many faiths and none. That tradition underlies and informs the common law. It draws not on religious authority but on its inherent reasonableness as to what is required in order to respect and promote everyone's real interests and rights in a critically tested, coherent and sustainable way.

3. The CBCEW was granted permission to intervene in this appeal by order of Laws LJ dated 22 December 2004. This written submission does not seek to deal comprehensively with the many issues arising from Munby J's judgment. It concentrates primarily on the central question whether patient autonomy is an absolute to which other key principles, notably the sanctity of human life and true respect for human dignity, take second place. Silence in respect of any particular proposition, whether articulated in Munby J's judgment or put forward by a party to, or intervener in, the appeal, does not necessarily imply agreement with that proposition.

4. In preparing this written intervention, the CBCEW has had sight only of the skeleton arguments lodged by the General Medical Council ("the GMC") and the Disability Rights Commission ("DRC"). The CBCEW would be grateful for the opportunity (a) to answer any questions that the Court of Appeal considers arise from these submissions; and (b) (if necessary) to make a short supplementary written submission in the light of further skeletons or

submissions lodged with the Court. The CBCEW confirms that it will attend by counsel at the hearing of the appeal.

Mr Burke's application, Munby J's judgment and its implications

5. Mr Burke's application for judicial review of the guidance promulgated by the General Medical Council ("GMC") arose because he wishes to ensure (by means of an advance directive) that he can continue, to the end of his life, to receive treatment (in particular, artificial nutrition and hydration: "ANH"). It therefore concerns the antithesis of the situation which is of real concern to the CBCEW, namely, the making of a suicidal advance directive, by which a patient intent on committing suicide seeks to force his medical team to acquiesce in that intent and to assist him in taking his own life. However, given Munby J's wide conclusions on the supremacy to be accorded to patient autonomy, his judgment has clear (and disturbing) implications for all advance directives and all patient decisions[1].

6. The logical consequence of applying the principle of "determinative" patient autonomy enunciated by Munby J is to impose upon those who have assumed the care of a patient an absolute legal duty to comply and conduct themselves in accordance with decisions and directives which the patient himself defines. That is so whether (as in the instant case) the patient requires continued treatment irrespective of his actual medical condition at any stage, or whether the patient has put in place a programme designed to assist him to commit suicide by withholding or discontinuance of treatment with intent to terminate his own life[2].

7. Munby J defines Mr Burke's application as giving rise to two broad questions:

[1] The CBCEW concurs with the Secretary of State's concern that the implications of Munby J's judgment may go far beyond the question of ANH and that there is a "very real possibility that the right of patient autonomy identified by Munby J, both at common law and under the ECHR, could be relied upon in support of requests for patients for life-ending treatment": Letter from the Office of the Solicitor, Department of Health to the Civil Appeals Office, 7 December 2004.

[2] Such "definition" is not a matter of formulae, but of what any reasonable hearer would understand to be indubitably an expressed intention to bring about his or her own death and to be assisted in doing so by a coordinated course of conduct involving (a) withholding of all life-sustaining treatment and (b) provision of palliative care with the intent of assisting this suicide by omission.

a. "first, the circumstances in which it is lawful for doctors to withhold or withdraw ANH", and

b. "secondly, the circumstances in which (if at all) that decision must first be referred to a court"[3].

8. Munby J identifies three principles as requiring to be reconciled: (i) the sanctity of life; (ii) individual autonomy and self-determination; and (iii) dignity[4]. He then places emphasis on the "absolute nature" of the principle of autonomy or self-determination[5]. The view that he takes (basing himself heavily upon certain dicta of Hoffmann LJ in *Bland*[6]) is that "it is not only autonomy which may have to take priority over the sanctity of life. Human dignity may also on occasions properly take priority"[7].

Summary of CBCEW position

9. The CBCEW's essential concern, which led it to seek permission to intervene in the appeal, is that Munby J went too far in the views he expressed on patient autonomy. In so doing, he created a situation that, as well as giving rise to practical difficulties for doctors and other healthcare professionals, opens the door to imposing on a patient's carers a legal obligation to assist in what – in reality, and by the patient's own unequivocal expression of his wishes – is suicide by a planned course of omissions. In so doing, Munby J accords patient autonomy a determinative status that it enjoys neither under the common law, nor under the European Convention of Human Rights.

10. The CBCEW fully agrees that patients have the moral right to refuse treatment that they see as futile or disproportionately burdensome (relative to the treatment's prospective benefits). It also accepts that, in English law, individuals have an even wider legal autonomy – namely, a legal liberty to

3 Para. 37. (Unless otherwise stated, all paragraph references in these written submissions are to the judgment of Munby J, [2004] EWHC 1879 (Admin), (2005) 2 WLR 43: (2004) 2 FLR 1121: (2004) Lloyd's Rep Med 451: (2004) 79 BMLR 126).
4 See e.g. Para. 51 (quoting Hoffmann LJ in Bland [1993] AC 789 at 826), Paras. 54-56 (autonomy) and Paras. 57- 58 (dignity).
5 See especially Para. 75.
6 See per Hoffmann LJ in Bland at p.830 and see below, Paras. 27 – 34.
7 At Para. 79.

refuse treatment, and a legal claim or right that that refusal be respected by others, even when the refusal is unreasonable, against the patient's best interests, and therefore morally questionable. That said, the CBCEW considers there to be both legal and moral limits to patient autonomy.

11. A first limit is that patients have neither a moral nor a legal right or authority to exercise their autonomy in such a way as to oblige their doctor or hospital to provide treatment past the point when, in the doctor's conscientious professional judgment, formed with due attention to the patient's own feelings and assessments, that treatment has ceased to be in that patient's "best interests" – that is, that it is no longer of any benefit to the patient, or is likely to cause the patient suffering disproportionate to any clinical benefit. A second limit is that patients have neither a moral nor a legal right to oblige their doctor or hospital to be accomplices in their articulated and manifest plan to commit suicide by refusing treatment.

12. In contending that these two limits constrain patient autonomy, the CBCEW in the present intervention differs fundamentally from the position adopted by Munby J.

13. The CBCEW further accepts that respect for the autonomy both of patients and of healthcare professionals necessarily also implies that:

    (1) patients have no duty to disclose their reasons for refusing life-sustaining treatment, even if those reasons are in fact suicidal; and
    (2) those involved in the patient's care have no legal duty to inquire what those reasons are, still less to require patients explicitly to state whether their reasons are suicidal or not.

14. That said, however, one's proper autonomy as a patient does not mean that one has a right to require others to provide (a) medical treatment which they honestly and reasonably judge to be against one's best interests, or (b) what

oneself defines to be assistance in one's suicide (i.e., the two limits to patient autonomy set out above).

15. The CBCEW recognises that the questions addressed by the GMC guidance are difficult and complex ones. They arise for decision on a daily basis in the real world, where facts are difficult to ascertain or predict and where individual feelings and attitudes – and indeed medical opinions – are irreducibly diverse. The GMC guidance must provide a practical, operational framework for medical practitioners, enabling them to reach an appropriate bedside decision in each individual case. The issue is, what propositions does the law need to articulate and insist upon so that both the GMC and individual medical practitioners, confronted with the need to make end-of-life decisions about a particular patient, will appropriately respect and uphold the principle of the sanctity of life, the closely associated principle of human dignity, and the principle of individual self-determination?

16. The CBCEW submits that Munby J erred in law in holding <u>without qualification</u> or <u>without sufficient clarification</u> that –

- "In the final analysis it is for the patient, if competent, to determine what in his own best interests" (Para. 213(f));
- "The personal autonomy which is protected by article 8 [ECHR] embraces such matters as how one (…) manages one's death" (Para. 213(h));
- "The dignity interests protected by the Convention include (…) the right to die with dignity" (Para. 213(i));
- the patient's "decision as to where his best interests lie, and as to what life-prolonging treatment he should <u>or should not</u> have, is in principle determinative [and] (…) the sanctity of life has to take second place to personal autonomy" (Para. 213m, emphasis added: that personal autonomy is earlier described in pares. 56 and 75 as "absolute");

- both under the Convention and at common law the patient's "decision that ANH not be started or, if started, that it be stopped" is [without qualification and unconditionally] "determinative" (Para. 214(a)).

17. These holdings are each, in part, contrary to sound principles recognized in recent authorities that were not considered by Munby J. In consequence, the CBCEW submits that Munby J's declarations 1, 4(a) and 5 that the patient's decision as to whether ANH should be provided to him is "determinative of the best interests of the patient" (Para. 225, [2005] 2 WLR 431 at 506-507) are wrong in law.

18. The CBCEW considers that the paragraphs of the GMC's guidance criticised by Munby J, *properly understood*, are lawful. However, the *adequacy* of that guidance as the basis for making end-of-life decisions that are lawful and in the public interest is dependent upon the decision-makers' adherence, in *applying* the guidance, to certain legal and moral principles that are neither sufficiently recognised in Munby J's judgment nor expressly enunciated in the guidance itself. Accordingly, the CBCEW respectfully invites the Court of Appeal to take the opportunity clearly to articulate the relevant principles that are binding both on medical professionals and on courts to whom disputed issues will in due course be referred.

19. On 7 April 2005, i.e. between the date of Munby J's judgment and the hearing of this appeal, the Mental Capacity Act 2005 ("MCA 2005") received Royal Assent. Whilst clearly pertinent by way of background, the MCA 2005 does not resolve the matters at issue in the appeal. The CBCEW nevertheless draws attention to the fact that the MCA 2005 does *not* endorse euthanasia. Rather, it expressly states that a person making a determination of best interests on behalf of a person lacking capacity must not be motivated by a desire to bring

about death[8]. It also preserves the existing law on homicide and manslaughter and assisting suicide[9].

Analysis

The three principles

20. The CBCEW agrees that three fundamental principles are here involved: (i) the sanctity of life; (ii) individual autonomy and self-determination; and (iii) dignity. Much of Munby J's decision is devoted to the principle of individual autonomy. Against that background, it is important to highlight the true meaning and importance of both the sanctity of life and respect for human dignity.

21. The "life" protected against intentional deprivation in Article 2 of the ECHR is not simply one attribute amongst others of the person under discussion. It is the very reality of the individual person and is intrinsic to the person's dignity, in the relevant and proper sense of that word.

22. The living human person retains under all circumstances the fundamental dignity of being a person, and thus of being in that respect the equal of every other person. That equality is a real status given to all of us with our existence. It is not merely attributed to us, still less granted to, or given to, or created for us by law. This real dignity and equality is violated by treating someone – for example an irreversibly unconscious patient – radically unequally, or by acting on the basis that the person would be better off dead and so can deliberately be killed by an act or a planned course of omissions.

23. Human dignity should not be confused with the more superficial idea and reality of "not being in an undignified position." Munby J formulates or quotes a number of *dicta* that fall into this confusion[10]. Everyone retains their

[8] Section 4 (Best interests): "(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death."
[9] Section 62 (Scope of the Act): "For the avoidance of doubt, it is hereby declared that nothing in this Act is to be taken to affect the law relating to murder or manslaughter or the operation of the Suicide Act 1961 (c. 60) (assisting suicide)."
[10] See Paras. 66, 79 and 147.

equal human dignity, however severe their disablement by illness or debility. It is for this reason that:

- intentional killing, by act or a planned course of omissions, is wrong and unlawful;
- suicide (although decriminalised) remains contrary to public policy as expressing an inadmissible valuation of self, and of human life under various adverse conditions;
- resource allocation cannot rightly or lawfully proceed on the basis of regarding some persons', or some class of people's, death as an "advantage" to be pursued by chosen means, active or passive.

24. For similar reasons, the phrase "right to die with dignity" is irredeemably ambiguous. Used in its legitimate sense, it refers to every dying person's entitlement not to be neglected, treated as disposable or as a mere cost and burden, and not to be intentionally killed by act or omission. It is, however, frequently used by those who campaign for euthanasia and the legalization of assisting suicide to mean the right to be killed at a time and in a manner of one's own choosing. The CBCEW contends that that is *not* an authentic right, and that it is, indeed, profoundly contrary to the public interest in preserving the well-being and equal dignity of the vulnerable and weakest members of the human community[11]. The public interest in preventing assistance in suicide[12] is not, in essence, an interest of "the state" or of "society" considered *en masse*. Rather, it is an interest of each vulnerable individual in society, and thus of each one of us in so far as we are vulnerable to anyone (not excluding ourselves) with an intent to end our life.

[11] In this respect, the CBCEW understands and endorses the concerns expressed by the DRC, as set out in Para.5 of their skeleton argument, which have led the DRC to intervene in this appeal.
[12] The public interest in preventing assistance to suicide is carefully reviewed and reaffirmed in *Pretty* Paras. 28-30, 54-55, 94-97 [2002] 1 AC 800 at 822C-824C, 830H-832H, 844H-846B ([2001] UKHL 61), and in *Washington v. Glucksberg* (1997) 521 U.S. 702 701 at 716,728-735 (US Supreme Court). See also *Rodriguez v. A-G of Canada* [1994] 2 LRC 136 at 178-190, 192-193 (Supreme Court of Canada). The opinions of the dissenting judges proceed on the erroneous basis that decriminalisation of suicide equates to the recognition or grant of a right of self-determination. This is the error identified by Lord Bingham in *Pretty* Para. 35 [2002] 1 AC 825D-G.

False conflict between the three principles

25. The CBCEW takes fundamental issue with Munby J's premise that there is an irreconcilable conflict between the three principles of (i) the sanctity of life; (ii) individual autonomy and self-determination; and (iii) dignity, and that *therefore* a choice must be made that accords one of the principles, with all its implications, universal priority over the others[13]. The CBCEW thus disagrees with Munby J's conclusion that, both at common law and under the ECHR:

> "(…) important as the sanctity of life is, it has to take second place to personal autonomy and may have to take second place to human dignity (...)"[14].

26. The CBCEW maintains that, on the contrary, when each principle is correctly understood, they complement rather than conflict with each other. Because personal autonomy properly understood is subject to limitations[15], it does not conflict with the sanctity of life. Similarly, the core principle of sanctity of life – the negative obligation not to intentionally kill – does not conflict with dignity. Even when deliberate killing is motivated by compassion or mercy, it fails accurately to take into account the dignity of the person killed. Suffering calls for relief, not extinction of life.

Munby J's use of certain dicta in Bland

27. Munby J placed great weight on dicta of Hoffmann LJ (as he then was) in *Bland*. He describes that decision (and in particular Hoffmann LJ 's analysis of the "cluster of ethical principles") as "central to the issues that arise for decision in this and other similar cases"[16]. Hoffmann LJ 's dicta are quoted in *extenso*[17] and the "crucially important" point on patient autonomy is described as being "adopted and elaborated" by Lord Goff of Chieveley (at p.864 of

[13] See Para. 79, quoting Hoffmann LJ in *Bland* at p.830. Earlier (Para. 75), Munby J quotes Hoffmann LJ's assumption (at pp. 826-827 of *Bland*) that there is a conflict between sanctity of life and self-determination, and his list of propositions / rhetorical questions. Should these be canvassed in argument before the Court of Appeal, the CBCEW would be most grateful for the opportunity to comment briefly orally (or in a written note) on the individual components there set out and relied upon by Hoffmann LJ.
[14] At Para. 127; see further Paras. 128-129.
[15] See Para. 15 above.
[16] At Para. 51.
[17] At Para. 73.

Bland) in an "equally important passage"[18]. Those passages form the basis for the conclusion[19] that "the principle of autonomy or self-determination" has an "absolute nature"[20].

28. The following is at the heart of Hoffmann LJ 's dicta in the Court of Appeal in *Bland*:

> "The patient who refuses medical treatment which is necessary to save his life is exercising his right to self-determination. But allowing him, in effect, to choose to die, is something which many people will believe offends the principle of the sanctity of life. Suicide is no longer a crime, but *its decriminalisation was a recognition that the principle of self-determination should in that case prevail over the sanctity of life*." [1993] AC 789 at 826H-827A (emphasis added)

29. The subsequent decision of the House of Lords in *Pretty* [2002] 1 AC 800, [2001] UKHL 61 was apparently not directly cited to Munby J[21]. Lord Bingham[22] there expressly rejected the proposition that the decriminalization of suicide was recognition of the right of self-determination or any other right. Lord Bingham analysed the legislature's reasons for that decriminalisation. He showed that they included no recognition of such a right, and concluded that, on the contrary:

> "[t]he policy of the law remained firmly adverse to suicide, as section 2(1) [of the Suicide Act 1961] makes clear."

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[18] At Para. 74.
[19] At Para. 75.
[20] In Para. 75, Munby J identifies (without specific references to particular passages) six other well-known cases which he considers emphasise the "absolute nature" of the principle of autonomy or self-determination. The CBCEW does not dispute the rulings or essential course of reasoning in any of those cases. However, it rejects the notion that any of them establishes or even purports to hold or state that the principle of autonomy is absolute. If there is a conflict between *Secretary of State for the Home Department v Robb* [1995] Fam. 127 at 131-2 and the dicta in the later case of *ex p. Brady* (both discussed below at Paras. 37 - 38), the latter should be preferred.
[21] The references at Paras. 59, 62, 118, 121, 124, 130, 133, and 140 are to the decision of the European Court of Human Rights in *Pretty*, not to the decision of the House of Lords. The main parts of Lord Bingham's leading judgment are, however, reproduced in the Statements of Facts in *Pretty v. UK* (2002) 85 EHHR 1 at Paras. 7-22
[22] Para 35, at 825D-G. Bingham MR (as he then was) sat with Hoffmann LJ in the Court of Appeal in *Bland* and quotes from Hoffmann LJ 's judgment in *Bland* at Para. 9 of *Pretty*.

30. In implicitly disapproving Hoffmann LJ 's explanation of the purpose and significance of the decriminalization of suicide in *Bland*,[23] Lord Bingham in *Pretty* also impliedly disapproved Lord Goff's implicit adoption of those remarks[24].

31. The Strasbourg judgment in *Pretty v. United Kingdom* (2002) 35 EHRR 1 does not invalidate these elements of the House of Lords' judgment in *Pretty*.[25]

32. *Pretty* was, of course, concerned with suicide by positive act; and a majority of the speeches in the House of Lords in *Bland* placed weight on the distinction between positive acts and omissions. However, the potential interrelationship between the two cannot be disregarded. In *Bland* itself, several speeches stated, arguably *obiter*, that where there is no duty not to omit life-sustaining treatment, such treatment can be omitted (withheld or discontinued) even if those doing so intend thereby to bring about death[26]. However, Lord Bingham specifically disagreed with the proposition that what was being declared lawful by the Courts in *Bland* involved intent to cause death[27]. He also considered that, in a case where someone makes an advance directive (while fully capable) directing discontinuance of life-sustaining treatment after three years in irreversible coma, there need be no intent to commit suicide, nor any intent, on the part of those who comply, to assist suicide[28].

33. If the decision in *Bland* depended on the proposition that the view that a particular patient's survival would not be in his or her best interests may lawfully be used as a premise for withholding life-sustaining treatment, the

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[23] That explanation appears to have been cited by counsel for Mrs Pretty: [2002] 1 AC at 805A.
[24] In the passage cited by Munby J at Para. 74. Munby J omits Lord Goff's approving allusions to the passage in which Hoffmann LJ refers to the decriminalization of suicide.
[25] Even if it had differed from the House of Lords in this matter, the court would not be right to set aside the House of Lords ruling: *Leeds City Council v Price* 2005 EWCA Civ 289, Times, March 17, 2005.
[26] See [1993] AC at 877B (Lord Lowry), 881C-D (Lord Browne-Wilkinson) and 887B and 896A (Lord Mustill).
[27] See [1993] AC at 815F.
[28] See [1993] AC at 814C-E.

CBCEW submits that *Bland* should be regarded as restricted to holding that (i) the appropriate *court* can entertain and proceed on the basis of that proposition; and that (ii) the proposition only applies in cases of irreversible unconsciousness ("true PVS"). The CBCEW draws attention to the warnings of Lord Lowry, Lord Browne-Wilkinson and Lord Mustill that such a proposition, by making "a distinction without a difference", is "almost irrational", and leaves the law "both morally and intellectually misshapen".[29]

34. The CBCEW submits, however, that the decision in *Bland* did *not* depend upon that proposition. As Robert Walker LJ pointed out at the end of his careful review of *Bland* in *Re A (Conjoined Twins)*[30], the four propositions sufficient to explain the decision in *Bland*, and agreed to by all members of the House of Lords, constitute a course of reasoning which

> "led Lord Goff to say, at p. 868: 'the question is not whether it is in the best interests of the patient that he should die. The question is whether it is in the best interests of the patient that his life should be prolonged by the continuance of this form of medical treatment or care.'"[31]

Thus, the order made in *Bland* did not involve intent to terminate life, or require approval of such intent.

Further authorities on patient autonomy

35. The CBCEW upholds the autonomy of adults and accepts that, as a matter of English law, a person of full age may refuse treatment for any reason or no reason at all, even if it appears certain that the result will be his death. The competent patient's moral right to proceed on a personal assessment of the anticipated benefits and burdens of a proposed or current treatment and, in consequence, to refuse or accept that treatment have long been accepted and

[29] See [1993] AC at 877B, E, 885G and 887D.
[30] [2001] Fam. 147, at 246D-249A.
[31] Whether or not the courts' answer to the latter question was inevitable and right, it is clear that Lord Goff's rejection of the former question cuts directly across Para. 11 of the GMC guidance, in so far as that part of the guidance implies that doctors *should* ask themselves precisely whether it is in the patient's best interests that he should survive or that he should die. The proper question is never whether life/survival or death is in the patient's best interests. It is whether the provision or non-provision of an identified possible treatment, necessary for sustaining the patient's life, is in that patient's best interests.

articulated in the established Catholic tradition of reflection and teaching on medical ethics.

36. Of the six cases primarily relied upon by Munby J[32] in further support of his reasoning on determinative patient autonomy, open-eyed refusals or withdrawals of consent to life-sustaining amputation (*In re* C [1994] 1 WLR 290), dialysis (*Re JT* [1998] 1 FLR 48), or ventilation (*Re AK* [2001] 1 FLR 129; *Re B* 2002 EWHC 429, [2002] 1 FLR 1090) are all well within the traditional conception of morally reasonable exercises of autonomy, and *a fortiori* within traditional conceptions of the liberty to make even unreasonable personal decisions about oneself.

37. In *Secretary of State for the Home Department v Robb* [1995] Fam. 127, Thorpe J's dicta stressed the scope of the right of self-determination in English law. They do not, however, treat the defendant prisoner's hunger strike as intended precisely to terminate his life (as distinct from attempting to achieve another purpose, such as manipulatively gaining access to non-medicinal drugs, with a willingness to press this campaign to the point of no-return). Nor did Thorpe J. unambiguously affirm[33] that a hunger strike or refusal of treatment could never amount to suicide[34].

38. Subsequently, in *R v Collins, ex p. Brady* (2000) 58 BMLR, [2000] Lloyd's LR Med. 355 (not cited to Munby J), Maurice Kay J upheld the lawfulness of force feeding in the best interests of an incapable person detained under the Mental Health Act 1983. Having heard arguments on the authorities[35], he accepted the invitation of counsel to rule on the case of an institutionalized

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[32] At Para. 75. Elsewhere in his judgment, Munby J draws on further *dicta* that are not expressly discussed in this written intervention. Should these be canvassed in argument before the Court of Appeal, the CBCEW would be most grateful for the opportunity to comment briefly upon them, either orally or in a written note.

[33] At [1995] Fam. 132A.

[34] The declarations granted by Thorpe J (at 129H-130A) were that the prison authorities "(1) may lawfully observe and abide by the refusal of the defendant to receive nutrition and (2) may lawfully abstain from providing hydration and nutrition, whether by artificial means or otherwise, *for so long as the defendant retains the capacity to refuse the same*" (emphasis added).

[35] Including Lord Keith's dictum in *Bland* that "the principle of sanctity of life (…) does not authorize forcible feeding of prisoners on hunger strike": [1993] AC at 859.

person with capacity, physically fit though detained in hospital for medical treatment for mental illness or disorder. His view[36] was that:

> "there should be circumstances in which state or public interests such as the ones identified in *Thor*[37] would properly prevail over a self-determined hunger strike so as to enable, even if not require, intervention".

39. Maurice Kay J. added[38] that:

> "it would seem to me a matter for deep regret if the law had developed to a point in this area where the rights of a patient count for everything and other ethical values and institutional integrity count for nothing."

40. The CBCEW submits that the law has indeed *not* reached that point, and should not embrace such a one-sided and absolutist concept of autonomy.

41. The Court of Appeal's decision in *St George's Healthcare NHS Trust v. S* [1999] Fam. 26 (a case that involved a fully viable unborn child) demonstrates that it is trespass to impose treatment on a competent person who is withholding consent to it, even if the treatment is urgently necessary to avert that patient's death[39] and is being refused without moral justification. It does not follow, however, that the patient's decision to accept or refuse treatment is "determinative of the best interests of the patient"[40]. Indeed, the Court of Appeal rightly proceeded on the basis[41] that the patient's decisions in that case, though fully competent, were in fact *contrary* to her interests.

42. The principle enunciated in *St George's Healthcare v S* is, properly analysed, a principle of liberty or immunity: a freedom from interventions on one's

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[36] At Para. 72 of his judgment.
[37] The public interests identified in *Thor v. Superior Court* (1993) 5 Cal. 4th 725 (Supreme Court of California) were four specific interests capable of prevailing over the right of self-determination, since that right is not absolute: (i) preserving life, (ii) preventing suicide, (iii) maintaining the integrity of the medical profession, and (iv) the protection of innocent third parties (see *Brady* Para. 70).
[38] At Para. 73.
[39] The case actually also involved the death of a fully viable unborn child; and the CWCEW reserves its position as to the moral and legal correctness of that consequential result.
[40] C.f. Munby J's gloss on this authority at Para. 225.
[41] See [1999] Fam at p. 46E; see also p. 51G.

bodily person by third parties against one's will[42]. That principle does not establish what a patient's best interests are. Still less does it impose duties (positive obligations) on other persons to proceed in all respects as they would be bound to do if the person withholding consent were acting in his or her best interests. Munby J's judgment and declarations (1), (4) and (5) err in asserting that that principle has those implications.

Importance of intention and double effect

43. The principle of double effect is well established in this area of English law[43]. The reality and importance of the commonsense concept of intention (as distinct from foresight of side effects, however important) are likewise affirmed by the Supreme Court of the United States in *Vacco v Quill* (1997) 521 US 793 at 802-803. This case[44] also provides helpful guidance that:

(1) The very extensive right to refuse medical treatment on the basis of personal autonomy (a right very firmly proclaimed in that case) is not absolute. It can be integrated with an ongoing public policy against suicide (and prohibition of assisting suicide). Suicide and assistance in suicide are there defined by reference to *intention*.

(2) A refusal of life-sustaining treatment can amount to suicide in a case where that refusal is *intended* to be the means of bringing about death[45]. The Supreme Court makes clear that

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[42] Whether this freedom is so wide as to prevent any intervention "without one's consent", so that it operates -- however unreasonable or wrongly motivated or contrary to public policy the patient's refusal is -- even when the patient is unconscious, is a further question that did not arise in *St George's Healthcare v S*.

[43] For example, *In re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147, 146, 199, 216 – 218, 251 – 252. See also Munby J writing extra-judicially in Andrew Grubb Ed, "Principles of Medical Law", Second Edition, Oxford University Press, 2004, Para 4.208 (Appeal Bundle 4, Tab 8, Page 1424).

[44] See also *Washington v. Glucksberg* 521 U.S. 702 at 742 per Stevens J. concurring.

[45] See 521 U.S. at 801-803, particularly the reference to *Fosmire v. Nicoelau* (1990) 551 N.E. 2d 77 at 82 and n.2, viz. the passages where the Court of Appeals of New York, upholding the right of a young and generally healthy mother to refuse life-preserving blood transfusions, ruled that "merely declining medical care, even essential treatment, is not considered a suicidal act", whilst at the same time stating (n.2) that "we in no way condone suicide and intend no inference in that regard (…) the injury here was not self-inflicted *nor does the patient want to die*" (emphasis added).

the law, "in the absence of omniscience," can reasonably uphold the autonomy right to refuse treatment without either

- assuming, claiming or pretending that no exercises of that right will be motivated by suicidal desire or intent, or
- abandoning the principle that suicide is contrary to public policy and the rule that assisting it is prohibited[46].

44. It is not possible to eliminate the issue of assisted suicide by erecting a legal doctrine that refusal of medical treatment by a competent person, irrespective of suicidal motive and intent, can never in law be suicide, or its corollary that a planned course of omissions deliberately coordinated with such a refusal of treatment can therefore never in law constitute assistance in suicide. So absolute a doctrine would be a fiction. That is the inescapable commonsense of the matter.

45. The CBCEW both asserts this reality and maintains that the proper relationship between the principles of the sanctity of life, self-determination and human dignity must not be distorted by making patient autonomy determinative, as Munby J has done.

Resource allocation

46. Early in his judgment, Munby J states emphatically that,

> "This is not a case about the prioritisation or allocation of resources, whether human, medical or financial. This case does not raise what Lord Hoffmann referred to in *Matthews v. Ministry of Defence* [2003] UKHL 4, [2003] 1 AC 1163, at Para [26] as questions of distributive justice (…) Nothing I say should be treated as necessarily having any application in a case where resources are an issue. Such a case may – I emphasise may: I express no views at all as to whether it will – raise very different and much more complex issues."[47]

[46] See 521 U.S. at 808 n. 12.
[47] At Para. 27 of the judgment.

47. The CBCEW notes, however, that it is easy for respect for human dignity and equality to be undermined by thoughts of the form—

- life of such and such a quality or kind is not worth living, so this person would be better off dead;
- for that reason, or simply because resources could be better used on other patients, it would be right to treat the early non-existence of this person as an advantage;
- therefore, that is a reason for discontinuing treatment which would sustain the life of this person.

48. Such reasoning runs counter to fundamental legal and moral principles that the courts should be vigilant to preserve, in the public interest. If those involved in a patient's care introduce, as a step or premise in their reasoning as to what treatment is appropriate, the criterion that costs could be saved or resources freed up by the patient's death, so as to reach the conclusion not to provide a particular treatment, it follows that they intend to bring about the patient's death by their deliberate withholding or withdrawing of that treatment. If and to the extent that the Court of Appeal is invited to consider the relevance of costs in decision-making about life-sustaining treatment, the CBCEW urges it categorically to condemn the use of such reasoning.

49. The CBCEW stresses that that the same conclusion (i.e., *not* to provide a particular treatment) may be reached perfectly lawfully on the basis (for example) that it will be excessively burdensome to the patient, or the priority (on some appropriate criterion) of another patient's need for the expenditure of those resources. The cost of providing a particular treatment to a certain patient or class of patients and / or the alternative claims on scarce resources are capable of being a lawful and reasonable ground for deciding not to provide that treatment to that patient or class of patients[48].

[48] Neither the medical placement of feeding tubes nor the provision of nutrition and hydration through these tubes – the two distinct elements of what is usually called compendiously "ANH" – are much more expensive than provision of other aspects of basic palliative care. It follows that in all normal

The medical evidence

General comments

50. The CBCEW has reviewed the medical evidence placed before Munby J and the conclusions that he drew from it[49]. It has also reviewed the witness statement of Dr Philip Howard that Medical Ethics Alliance, Alert and the British Section of the World Federation of Doctors Who Respect Human Life seek permission to lodge as part of their proposed intervention. The CBCEW draws specific attention to the following elements that emerge from consideration of that material:

(1) Munby J's classification of patient conditions into three stages – patient suffering from an incurable illness, patient terminally ill, patient dying – is broadly correct, although there are some classification problems (e.g., in relation to pure PVS) and there is no "brightline" division to be drawn between the categories.

(2) Clinical experience does not support the proposition that the patient can decide what is in his/her best interests without recourse to the clinical expertise and experience of the treating doctor and other relevant healthcare professionals;

(3) The introduction and maintenance of any treatment including ANH is not neutral – thus, for any particular patient at any particular stage, it may be appropriate to introduce a particular treatment and then, after a trial period, review its effectiveness;

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circumstances, resource allocation issues should not be a factor in deciding whether to provide ANH (or other comparably inexpensive life-sustaining treatment or care) to patients who have never expressly asked for them.

[49] Including the witness statements of a) Sir Cyril Chantler (Appeal Bundle 1, Tab 11) b) Professor Irene Higgison (Appeal Bundle 1, Tab 12), c) Witness Statement of Dr Michael Wilks (Appeal Bundle 2), d) Jane Campbell ((Appeal Bundle 3, Tab 1), d) and e) Dr Peter McCullagh (Appeal Bundle 2, Tab 14).

(4) withdrawal of a particular treatment is not necessarily distressing if other appropriate palliative care is put in place, but treatment should only be so withdrawn if it is futile or unduly burdensome to the patient – it *must not* be withdrawn with intent to shorten or end life;

(5) The question of whether a particular treatment is of no therapeutic benefit to a particular patient at a particular stage in their illness or condition (i.e., futile) can only be addressed in a clinical context, by drawing upon the independent clinical expertise and experience of the doctor and other health care professionals;

(6) The question of whether a particular patient would find a particular treatment disproportionately burdensome is for that patient to make himself (if capable) – if he is incapable, it must be made by others on the basis of his best interests[50];

(7) The right to a second opinion is an integral, and essential part of ensuring that patients are able to exercise their right to self-determination, *within* the proper limits, against a background of compassionate and effective clinical expertise.

The specific issue of providing ANH

51. On the one hand, the insertion of a line or tube, and to some extent the monitoring of tube and patient and the prescription of substances to be provided, do involve a degree of medical and/or nursing expertise. In that sense these can be considered instances, as held in *Bland*, of "medical treatment". They are medical decisions, and are subject to the normal criteria for medical intervention. On the other hand, the provision of nutrition and hydration, even through use of such artificial and

[50] Within the framework of the principles discussed above and the Mental Capacity Act 2005.

medically initiated and monitored means, is in itself a natural human act of solidarity with fellow human beings[51]. As such, it is to be presumed obligatory unless burdensome or futile. It is not to be regarded as "medical and therefore optional".

52. There are circumstances where provision of nutrition and hydration is futile, because it cannot be absorbed by the patient (for example, where death is imminent). But the CBCEW agrees with the DRC[52] that the provision of nutrition and hydration is *not* futile where it is keeping the patient alive. This benefit is not to be overlooked in considering whether, nevertheless, continued provision of ANH is too burdensome to the patient.

53. Burdensomeness and / or futility are the morally appropriate criteria on which to base a decision to withhold or discontinue ANH. It is never morally right to proceed on the basis that non-provision of ANH is a convenient way (a <u>means</u>) to end the patient's life, which would result in saving various (consequential) costs. Equally, it is not lawful to proceed on that basis, since doing so implies intent to bring about death, and the adoption of causally relevant means to achieve that end.

54. Moreover, the risks that non-provision of ANH may be used with such intent, or that the test of burdensomeness or futility will be applied too loosely, are so great that the law[53] has sensibly adopted a demanding threshold of burdensomeness in relation to cases where the patient is neither imminently dying, nor capable of deciding about ANH. In such cases, where the provision of ANH is keeping the patient alive, maintaining ANH should not be regarded in law as too burdensome unless the patient's life, if so prolonged, would be intolerable (the "intolerability test").

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[51] Hoffmann LJ rightly says in *Bland* [1993] AC at 832D-E that

> "It is, I think, the duty to act with kindness and humanity which leads people to say that, whatever may be the position about artificial medical treatment, it cannot be right to deny the patient food. The giving of food to a helpless person is so much the quintessential example of kindness and humanity that it is hard to imagine a case in which it would be morally right to withhold it. (…) American writers have referred to these qualms about denial of food as the 'sloganism' and 'emotional symbolism' of food. I do not think that one should make light of these deeply intuitive feelings, which derive, as I have said, from a principle of kindness which is a badge of our humanity."

[52] At Para. 26 of its skeleton.

[53] As expounded by Munby J. at Paras. 105-113.

The doctor's duty

55. The CBCEW agrees with Munby J's general statements about the duties of doctors and hospitals.[54]

56. The CBCEW strongly maintains that those responsible for the patient's care should be legally free to terminate that responsibility, in an appropriate and responsible manner, if a patient seeks to exercise his autonomy so as to require them:

    (1) to continue a particular treatment or ANH irrespective of their own best professional judgment as to its efficacy or its effect upon the patient in his present condition; or

    (2) to desist from a particular treatment or ANH in order to assist a patient to fulfil his specific and expressed intent[55] of committing suicide.

57. Additionally or alternatively, in such extreme cases they should seek the guidance of the Court as to how then to proceed. In the interim they should be free to continue life-sustaining treatments which they judge to be in the patient's best interests, at least while the patient is unconscious or, though conscious, is unresisting. There is, however, no legal or moral obligation on them positively to seek out a specific doctor or facility, to whom the patient can be transferred, prepared to give effect to the patient's wishes[56]. Nor should the court direct them to do what would amount to assisting the patient to carry out a purpose self-defined by the patient as suicidal. In those respects, the principle of patient autonomy is not legally or morally "absolute" or "determinative" in the sense indicated or assumed by Munby J.

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[54] At Para. 191.

[55] The term "intent" here used as it is understood in the well established medical "principle of double effect", and not as the term is taken by a kind of legal fiction, in certain legal contexts, to include foreseen effects. It means that one should not *try* to bring about death, either as an end or as a means, by act or omission. The principle is not confined to the medical context: see *Vacco v Quill* (1997) 521 US 793 at 802-803.

[56] This proposition is not inconsistent with the view expressed by Munby J (para. 193) that, "the court can by appropriate orders ensure that a patient who *ought* to be treated is, if need be, transferred to the care of doctors who are willing to do so" (emphasis added).

58. To place doctors and other healthcare professionals under a legal obligation to give determinative effect to patient autonomy would gravely undermine the legal public policy against suicide and the vital public interest in having a medical profession that abjures intent to bring about death. It would degrade the medical profession and place unacceptable fetters upon the professional judgment and moral autonomy of healthcare professionals.

Involving the court

59. The CBCEW agrees with Munby J's general statements about the powers of the court[57]. It is fully aware of the need to ensure that:

    (1) the (often difficult and sensitive) cases where there is genuine disagreement or uncertainty as to best interest be submitted to a court for prior judicial sanction of decisions on end-of-life treatment; whilst

    (2) ensuring that decisions that can and should reasonably be taken without recourse to the judicial system are made by the responsible (and accountable) doctor against a clear understanding of the relevant legal rules and principles.

60. The CBCEW considers that the specific criteria laid down by Munby J[58] may, in some particulars, place excessive emphasis on the need for prior judicial sanction and thus result in an over-burdening of both the medical and judicial systems. On the other hand, where nutrition and hydration are concerned, it right for the law to be very cautious. The CBCEW therefore suggests that, if the categories set out by Munby J[59] are to be whittled down, the Court of Appeal should leave the

[57] At Paras. 193, 195 and 196.
[58] At Para. 202, read with the analysis of *Glass I* and *Glass II* and the conclusion drawn at Para. 210. Those criteria draw upon, but gloss and expand, the criteria laid down by Coleridge J in *D v An NHS Trust (Medical Treatment: Consent: Termination)* [2003] EWHC 2793 (Fam), [2004] 1 FLR 1110 [2004] Lloyd's Rep. Med. 107 and approved by the President of the Family Division, which were cited by Munby J at Para. 199.
[59] At Para. 202.

responsible decision-makers in no doubt as to four key elements in the legal framework:

(i) withdrawal of nutrition and/or hydration with the intent, and as a means, of bringing about death is unlawful;

(ii) provision of nutrition and hydration is not futile if it is keeping the patient alive;

(iii) the benefit of being kept alive is not to be overlooked in the assessment of whether provision of nutrition and hydration is too burdensome to be required or warranted;

(iv) where the patient is not in the process of imminently dying, and is not capable of directing that nutrition or hydration be withdrawn, nutrition and hydration should be maintained unless the intolerability test is satisfied.

The outcome of the appeal

61. The CBCEW does not consider the paragraphs of the GMC guidance impugned by Munby J to be unlawful *per se*.

62. The CBCEW is not requesting the Court of Appeal to make a specific ruling in relation to suicide / assisted suicide in the context of the present appeal. Its purpose in spelling out the implications of permitting determinative patient autonomy where there is expressed suicidal intent has been to indicate why it is important that, in its judgment, the Court of Appeal should correct the position arising from the judgment of Munby J below.

63. The CBCEW respectfully invites the Court of Appeal:

(1) to indicate expressly that the principle of patient autonomy cannot be regarded as an absolute, or as wholly or simply

"determinative" of what course of action doctors and other health care professionals must pursue in order to discharge their duty of care towards their patient;

Alternatively and minimally:

(2) to avoid making or endorsing any general statements of principle in relation to advance directives and / or the principle of patient autonomy which (for want of appropriate qualification) might be taken to elevate the principle of patient autonomy above the public interest in

- the sanctity and preservation of human life;

- the protection of the vulnerable from insidious pressures to choose their own death by any legally available means including renunciation of life-sustaining treatment or food or water, however delivered;

- the maintenance in the healthcare professions of an unequivocal opposition to, and abstention from, all forms of intent to bring about death, whether by act or omission; and

- the protection of healthcare professionals and institutions from compulsory complicity in planned courses of conduct expressly defined by the patient as suicidal and / or assistance in suicide.

64. By so doing, it will ensure that the true criteria of lawfulness and public interest are in the minds of decision-makers as they apply the GMC's guidance[60].

Conclusion

65. The moral principles that must be applied by a doctor following the GMC's guidance are very clear: sanctity of life, dignity and the individual right to self-determination. Making the decision that is legally and morally correct in an individual case requires the decision-maker to respect the proper relationship between these principles. It is a difficult exercise, involving a prudential judgment in each individual case. The CBCEW urges the Court of Appeal to reaffirm the practical legal framework that results from a correct reading of all the earlier authorities, in particular *Pretty*. The CBCEW also recognises that, in individual cases, there may be a genuine dispute over the most appropriate course of action. In such circumstances, it will necessarily fall to the court to arbitrate.

66. The GMC's guidelines are acceptable in so far as they are read within a legal framework that respects the proper relationship between sanctity of life, dignity and patient autonomy. Applied against the legal framework set out by Munby J, the results could be unacceptable, because of the overemphasis that he places on patient autonomy, to the exclusion of those other, fundamental, values.

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[60] There is an underlying danger that a decision-maker may mentally substitute short-hand analysis (by appealing to generic medical opinion that enjoys a degree of professional currency and / or endorsement) for the more onerous task of reaching a correct moral and legal decision in a particular case: c.f. the growth of voluntary *and* non-voluntary euthanasia in the Netherlands and Belgium.

EC4Y 7EX

27th April 2005

IN THE COURT OFAPPEAL **CO/004/2086**

ON APPEAL
FROM THE ADMINISTRATIVE COURT

MUNBY J [2004] EWHC 1879 (Admin)

BETWEEN:

THE GENERAL MEDICAL COUNCIL
Appellant

– and –

OLIVER LESLIE BURKE
Respondent

– and –

THE OFFICIAL SOLICITOR
Interested Party

THE DISABILITY RIGHTS COMMISSION
Interested Party

– and –

THE CATHOLIC BISHOPS CONFERENCE OF ENGLAND AND WALES
Intervener

– and –

THE SECRETARY OF STATE FOR HEALTH
Intervener

– and –

PATIENT CONCERN
Intervener

INTERVENTION OF THE CATHOLIC BISHOPS' CONFERENCE OF ENGLAND AND WALES (FOR HEARING 16-19 MAY 2005)

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