

Primary Care Trusts and the NHS (Performers Lists) Regulations 2004

Mark Meryon, Partner, Employment Department

The NHS (Performers Lists) Regulations require every Primary Care Trust ('PCT') to keep a list of persons performing primary medical care. All doctors, dentists, opticians and pharmacists (including locums) must now be on this list to perform services for NHS patients.

The aim is to provide a system where independent practitioners are regulated, quality is improved, and those whose fitness to provide services is in question can be helped or removed.

The regulations contain detailed provisions governing the admission, suspension or removal of a practitioner from the list, although in all cases protection of patients will be the overriding consideration.

Mandatory removal

A PCT must remove a practitioner from its performers list if it becomes aware that they:

- have been convicted in the UK of murder;
- have been convicted of an offence in the UK for which they were imprisoned for over 6 months;
- are subject to a national disqualification; or
- are no longer a member of the relevant health care profession.

The practitioner has no right of appeal, although the decision can be challenged in the civil courts.

Discretionary removal

A PCT may remove a practitioner in the following circumstances:

- his continued presence on the list would prejudice the efficiency of the services which those on the list perform (poor performance);
- he is involved in fraud in relation to any health scheme (misappropriation of NHS assets);
- he is unsuitable to remain on the list (covers many grounds)
- he has not performed the services within the PCT area within the preceding 12 months.

When considering whether to remove a practitioner, the PCT must have regard to criteria set out in the regulations specific to each circumstance, and in general terms should consider:

- the nature of any incident;
- the length of time since any incident;
- whether there are any other any incidents and any action taken;

- the relevance of any incident to the practitioner's work, and likely risk to patients, or public finances;
- whether the practitioner has been suspended, removed or refused admittance to any other primary care list, and the facts behind such action.

The duty to protect patients must be the overriding factor when deciding what action is necessary.

Investigations

As a matter of good practice, all PCTs should have in place standard procedures for dealing with concerns about a practitioner's conduct. This will ensure consistency and thus fairness and thereby minimise the risk of unlawful discrimination. This may include appointing a board member with formal responsibility for making decisions, and a separate investigating officer who will follow a formal investigatory procedure and report on the issues and seriousness of the allegations and make recommendations for action.

Procedure

If a PCT is considering removing a practitioner from its lists, it must ensure the following:

- the practitioner is notified in writing of any allegation against him and what action it is considering;
- the practitioner must be given 28 days to make written representations from the date of receiving the notification;
- the practitioner must have the opportunity to put his case at an oral hearing which takes place before a decision is reached;
- once a decision is reached the PCT must notify the practitioner within 7 days of making the decision;
- the practitioner has the right of appeal, which must be taken within 28 days of being informed of the decision.

If there are serious concerns about a practitioner, the PCT may implement urgent measures to restrict their practice whilst the above procedure is taking place, for example, imposition of conditions, suspension, or referral to the practitioner's regulatory body.

At the conclusion of its investigations, if the circumstances are serious, the PCT may apply to the FHSAA for a national disqualification within 3 months of making its decision. The effect will be to exclude the practitioner from all PCT lists in the UK.

Alternatives

In discretionary cases, it may be appropriate to resolve the issue by remedial and/or supportive action before patients are put at risk.



Janet Sayers
Head of
Healthcare

Welcome to Kennedys' Healthcare briefing. In this edition we look at some topical issues to coincide with our attendance at the NHS Alliance Conference and Exhibition.

I look at the contentious area of consent and the patient's rights to make an autonomous choice and there is also a review of the recent case of Burke; these articles and the one on Coroner's Verdicts look at the implications of the Human Rights Act.

We also look at violence in the work place and the HSE guidelines in relation to this and NHS (Performers Lists)

Regulations and procedures for dealing with concerns about a practitioners conduct.

Finally we comment on bed-blocking and how PCTs could be affected by the Community Care Act and the increasing right of patients who face undue delay for treatment being entitled to access equivalent services in other EU member states at the expense of the NHS.

I hope you find these articles interesting and wish you all a good conference in Bournemouth.

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Consent and the Human Rights Act

Janet Sayers Head of Healthcare

Except in emergencies, consent is required for any medical treatment which involves touching the patient otherwise medical practitioners may face civil or even criminal proceedings for assault.

Form of consent

Written consent provides the clearest proof that the patient has consented to a procedure and for that reason is preferred by health service bodies when they may subsequently have to defend legal proceedings. The NHS Executive has provided a series of model consent forms for Health Authorities and Trusts.

Valid consent

The validity of a patient's consent depends on a number of factors. To be valid, consent must be 'real' and this means, patients must be competent or able to give consent. They must know in broad terms what they are consenting to and they must give their consent freely and without being deliberately misled.

The basic rule is that a medical practitioner is entitled to assume that his patient is able to consent to or refuse treatment. The fact that a patient does not appear to the professional to make a wise choice is not itself evidence of incapacity.

The leading case on adult competency is *F v West Berkshire Health Authority* where the Court said a patient should be able to appreciate what will be done to them if they accept treatment, the likely consequences of leaving their condition untreated and understanding the risks and side effects that the health professionals explain to them.

In *Re C* (1994 All ER 819 FD) the Court was asked to apply the test for competence to a paranoid schizophrenic patient in Broadmoor. In that case, the patient's leg was gangrenous and doctors advised it should be

amputated, otherwise the patient risked death. The patient refused to consent to the procedure and sought a declaration from the court that the amputation could not proceed without his consent. The Court held that the patient must understand the nature, purpose and effects of the proposed treatment which includes (i) having a comprehension and retention of the information about treatment, (ii) believing that information, and (iii) weighing up that information in the balance so as to arrive at a choice. The patient's general incapacity due to schizophrenia was irrelevant. His understanding of the operation proposed on his leg was all that mattered. The Judge found that the patient understood the choice he was being asked to make and consequently was competent to withhold his consent. The Court made an order forbidding the amputation without the patient's written consent.

Informed consent

How much information should the patient be given? English law does not require consent to be fully informed but if medical practitioners fail to counsel patients in a way recognised by their peers as appropriate then they may be negligent (*Sidaway*). This important aspect of consent is governed by the test of "What would a responsible body of opinion have discussed?".

It was argued in that case that patients had a right to decide what happened to them. The House of Lords (which decided the case) believed this right was supported by a further right to be given all information that is 'material' in deciding whether to accept the treatment advised. If a 'material risk' was not disclosed then the doctor responsible for counselling the patient was negligent. In order to decide whether something was a material consideration, the court should ask whether a reasonable person in the patient's position would have regarded it as being significant. To operate the test in clinical practice, medical practitioners therefore have to ask themselves what a



reasonable person in their patient's position would want to know. The Court imposed an important limitation on this obligation. The defence of 'therapeutic privilege' enabling doctors to withhold even material facts if they reasonably believe that disclosure would pose a serious threat of psychological detriment to the patient.

Article 3 of the European Convention on Human Rights states that no one shall be subjected to torture or to inhumane or degrading treatment or punishment. This is an absolute right and treatment given without consent is likely to fall within the ambit of Article 3.

It would appear, however, that provided clinicians demonstrate that they properly considered the patient's best interests and can justify any decision not to discuss relevant information with the patient, a Court is unlikely to find

that they acted negligently or assaulted the patient. Once again it would be advisable in light of the Human Rights Act (HRA) to discuss all risks or complications that occur at a significant rate, i.e. all those 'material' risks and in particular where any risk might result in significant consequences either to the patient or patients generally. If any complication or risk is to be omitted from discussion with the patient then record your reasons for doing so clearly in the notes. Any omission of a material risk should be the decision of the consultant in charge of the patient and in private practice, the clinician under whose care the patient has been admitted.

While the HRA does not affect the requirement of obtaining consent to a procedure, clinicians must be more aware, particularly of any information that they are not discussing with the patient. Protocols should specifically

refer to the HRA and you should review your consent forms to ensure that they comply with the Act, that clinicians are aware of the HRA and its impact on consent and make sure that they record their reasons for not discussing any issue with a patient.

Legally incompetent patients

Medical practitioners are obliged to treat these patients in accordance with the 'best interest' principle and, providing they do so, there is no need for prior authorisation from a court because the lawfulness of the treatment depends on it being in the interests of the patient. There are some categories of case where it has been suggested that it is good practice to seek court approval. For example, the withdrawal of life sustaining care from patients in a persistent vegetative state (*Airedale NHS Trust v Bland* 1993 1 All ER 821) or sterilisation operations on incompetent patients.

- (1) Mentally incompetent – generally if a patient is unable to make a decision then the medical practitioners must act in the patient's best interest. Treatment will be lawful providing a responsible body of professional opinion would accept that it was in the patient's best interest.
- (2) Minors – parents may consent on behalf of their children until they reach the age of 18. Following the case of *Gillick v West Norfolk & Wisbech Area Health Authority* (1985 3 ALL ER 402) however a child under 18 may be competent to consent if he achieves sufficient understanding and intelligence to understand fully what is proposed.

Consent, or refusal of consent, may be as a result of undue influence. If that is the case, the consent would not be voluntary and would be invalid. This was considered by the Court of Appeal in *Re T* (1992 4 ALL ER 649). In that case a young woman told hospital staff, when admitted to hospital after a car accident, that she did not wish to have a blood transfusion. She made that decision after talking to her mother, who was a Jehovah's Witness. The Court of Appeal decided that while it was to be expected a patient will seek advice before deciding whether to accept treatment, it was possible that their will might be overborne by pressure brought by others or in this case, the patient's mother. The refusal of consent to treatment was therefore invalid.

Article 6 of the HRA provides the right to a fair trial. It is arguable that hospitals will now have to apply more frequently to the Courts for declarations of incapacity and for approval that a proposed treatment is in the patient's best interests. If a clinician considers a patient is incompetent but the patient's relatives disagree then an application to Court should be made.

The HRA does not alter the position where a patient with capacity refuses treatment as it is clear that their wishes must be respected whatever the consequences.

Withholding or withdrawing treatment

This was debated in July 2004 in the case of *Burke* (discussed later). It is an area where the HRA has had an effect. A number of Articles apply, for example Article 2 the right to life; Article 3 the right to freedom from torture and inhumane or degrading treatment; Article 8 the right to

respect for private and family life and Article 14 a prohibition or discrimination on the grounds of age.

Article 2 is an absolute right to life which at first glance conflicts with the existing principle that clinicians need not intervene, or may withdraw treatment if they consider it is in the patient's interests to do so. This is the Article most often cited where clinicians want to withdraw treatment or not intervene which will result in a patient's death. Courts have held that it is incorrect to interpret Article 2 as meaning that a decision to cease treatment in the patient's best interests is an intentional deprivation of life. So where a responsible clinical decision was made to withhold treatment as it was in the patient's best interests and the clinical decision was made in accordance with a respectable body of medical opinion, the state's obligation under Article 2 was discharged.

The Courts have held that as always, providing a clinician is able to show that the decision is in the best interests of the patient then it will be lawful.

Indeed earlier this month the Court considered the case of *Charlotte Wyatt* where Portsmouth NHS Trust applied for a Court Order, allowing it not to send Charlotte for artificial ventilation or similar aggressive treatment. (The Trust would have to send Charlotte to another local Trust for artificial ventilation.)

The Court had to decide what was in Charlotte's 'best interests' and this encompassed medical, emotional and all other welfare issues. The Court did not believe 'that any further aggressive treatment, even if necessary to prolong life' was in Charlotte's best interests and granted the Order sought by Portsmouth NHS Trust.

You can do no better than keep relatives closely advised of any decision and your reasons for doing so. If it is clear that the patient's relatives do not agree with the decision then seek legal advice. As always, a clinician must be able to show that the decision is in the best interests of the patient.

Justifying treatment without consent

Emergencies justify treatment without consent as long as it is in the patient's best interests. Emergencies are in essence an example of implied consent.

- (1) In the case of nursing care which deals with personal hygiene, dressing and feeding.
- (2) Cases of public policy. This only applies where the patient is unable to consent and treatment against the wishes of the patient cannot be justified.

Conclusion

The Healthcare profession has seen a progressive change in attitude to clinical judgment. Whereas once 'doctor knew best' and the law advocated medical paternalism, anti-nanny tendencies in our modern consumer society recognise a patient's right to make an autonomous choice. To avoid the risk of litigation in cases where consent is paramount, the medical profession must resort to detailed written consent forms.

Jumping the queue by going for treatment abroad: Who pays the bill?

Christopher Malla Partner, Healthcare Department

The recent Judgment in *Watts v Bedford Primary Care Trust* ('the PCT') has profound repercussions for the NHS as it potentially opens the floodgates to patients who face undue delay for treatment being entitled to access equivalent services in other EU Member States at the expense of the NHS.

refusal to fund treatment abroad, Mrs Watts travelled to France and in March 2003 she underwent bilateral total hip replacements on a private basis at a cost of £3,900.

Whilst established principles of English law denied Mrs Watts an effective remedy, the European Court of Justice's (ECJ) recent case law implies that free movement of services may also be taken to mean (under specified circumstances), that nationals in one EU country can have medical treatment paid for in another at public expense. Accordingly, Mrs Watts, relying on EU legislation, applied for Judicial Review seeking a reimbursement of her costs of treatment abroad.

High Court Judgment

The Judge held that EU law permitted the UK to refuse treatment abroad if the same or equally effective treatment could be obtained without 'undue delay' within the NHS. He considered a period of a year represented 'undue delay', although the revised timeframe of 3-4 months was not. No further guidance was given as to what would constitute 'undue delay'.

What is interesting is that the Judge's decision regarding 'undue delay' did not start from when Mrs Watts was initially referred by her GP to the PCT or when she was added to the waiting list in October 2003. The 'undue delay' clock did not start ticking until the PCT made its reassessment of Mrs Watts as a 'soon' case.

Whilst Mrs Watts was refused reimbursement the Judge held that:

- The increase in costs to the NHS is a purely economic consideration which cannot justify a restriction on the fundamental freedom to provide services.

- The national waiting time applicable in any particular case is, in most cases, unlikely to be a significant factor.

- The Department of Health's Guidance on prior authorisation may be a breach of EU law as it creates a barrier to and restricts freedom to provide services.

This is a far reaching Judgment that may have a significant impact on the NHS. It potentially opens the door to treatment abroad, funded by the NHS if there is 'undue delay'. Normal waiting lists or the additional expense to the NHS will not be relevant factors when deciding whether a patient request for treatment abroad may be declined.

Court of Appeal Judgment

Whilst the Court of Appeal delivered its Judgment at the end of February 2004 it did not come to any conclusion as it referred a number of issues to the ECJ. Its Judgment is awaited. The Court of



Factual Background

Mrs Watts, a 72 year old woman suffering from osteoporosis, was on a one year waiting list for a bilateral total hip replacement in October 2003. She sought earlier treatment and wrote to her PCT to support her application to undergo surgery abroad paid for by the NHS.

The PCT refused Mrs Watts' request and argued that she was a 'routine case' and that treatment was available within the Government NHS Plan targets for access to inpatient treatment of 12 months. She was, therefore, not a candidate that warranted treatment abroad and authorisation was declined.

Mrs Watts' condition deteriorated and she was recategorised as a 'soon' case to undergo surgery in 3-4 months (i.e. by April or May 2003). The PCT remained unable to support treatment overseas. Despite the PCT's

Appeal queried whether it was the ECJ's intention to allow patients to jump the queue by having medical treatment in another Member State in view of the impact on an already strained NHS budget and the possible postponement of more urgent treatment needed by others. The Court of Appeal accepted that 'undue delay' is a matter of 'clinical judgment' but also stated that the decision on whether Mrs Watts' total hip replacement should have been performed abroad should not have taken into account waiting lists conditioned by economic considerations.

The Court of Appeal did not, however, address the crucial issue: what amounts to 'undue delay'? It acknowledged that if acceptable delay is not tied to properly administered NHS waiting times, by what criteria was the Judge able to determine that a year delay for the present claim was excessive but a delay of 3-4 months was not? The Court further stated that Mrs Watts, who had severe pain in both her hips, should ideally have them replaced immediately and asked "What criteria

justifies departure from the ideal? At a practical level, these are critical questions. Without clear answers, there are likely to be numerous time-consuming and expensive disputes".

Unfortunately, the Court of Appeal was not able to give PCTs and the NHS clear guidance as to what amounts to 'undue delay' when taking into account the funding of treatment abroad. Until the European Court clarifies the position, the impact of the first instance Judgment in the Watts case would appear to be undiminished and it is a matter of clinical judgment as to whether there has been 'undue delay'. This potentially opens the door for NHS patients who have been on waiting lists for several months to seek prior authorisation to undergo treatment abroad. If authorisation is refused they are free to challenge the decision by way of Judicial Review with the NHS facing the prospect of funding the cost of private treatment abroad.

PCTs must be able to demonstrate that they have made objective and impartial decisions on patient requests for treatment abroad and should consider the criteria they are currently using and the way this is communicated to ensure they are not open to challenge. The Court's ruling highlights that the criteria for a decision cannot focus purely on NHS waiting times as the determinant of what constitutes 'undue delay'.

While the ECJ's Judgment on the issues raised by the Court of Appeal is awaited, this may not be given for several years.

Violence in healthcare workplaces – ignore HSE guidelines at your peril

Sean Elson, Assistant Solicitor, Health and Safety Department

The latest figures for violence at work published in February 2004 and contained within the British Crime Survey [BCS] showed that the incidence of physical assaults and threats has fallen across all industry sectors from a high in 1995¹. compared to a 13% increase it reported for 2001-2002 identified by the House of Commons PAC².

The BCS report emphasised, however, that those employed within the 'protective services' remained most at risk of workplace violence. Of those professions the health and social welfare associate professionals, are considered at risk with 5% having experienced violence.

The HSE define work-related violence as 'any incident in which a person is abused, threatened or assaulted in circumstances relating to their work'. This definition is clearly very wide and in simple terms means that violence is not just actual physical harm but also the threat of it.

It would be reassuring to think that when a member of staff within a healthcare situation was attacked or threatened, often by someone under the influence of drinks or drugs, that the blame would fall fairly and squarely on the shoulders of the offender but this is not always the case.

There have been a number of drives initiated by government to deal with the issue of workplace violence with a view to increasing the level of prosecutions³ and it is clear from sentencing authorities that anyone who attacks a member of healthcare staff should expect an immediate sentence of imprisonment⁴ whilst this is welcome news to the health care professionals the health and safety implications that might arise from such an attack gives cause for concern.

The Health Services Priority Programme 2001-2004 was drawn up as part of the Health and Safety Commissions Strategic Plan. The first two years of this programme concentrated on manual handling and workplace violence and mainly targeted those trusts with the largest number of reported accidents. During those first two years 115 trusts have been inspected.

The HSE's report on inspections for the periods 2002/02 and 2002/03 reported that most trusts had made some progress on workplace violence in developing policies, assessing risk and implementing controls. However, the level of compliance, was described as 'patchy' and in doing so referred to the number of Improvement Notices issued. 25 notices relating to violence and aggression were issued to 23 NHS trusts.

In the 2003/04 Inspection Plan of the HSE Field Operations Directorate [FOD] to its inspectors concerning the Health Services Priority Programme, reference was made to what it describes as 'high-profile' enforcement results. In particular, the successful prosecution of North Sefton & West Lancashire NHS Trust, where two support workers were physically assaulted by a patient whilst on holiday. That trust was fined £12,000. The plan also highlights a 'significant increase' in the number of improvement notices served on the two main inspection topics of manual handling and violence.

The RIDDOR regulations define accidents as including 'acts of non-consensual physical violence' and such an incident would need to be reported if the worker is unable to undertake their full range of duties, or is absent from work, for a period in excess of three days.

However, this is not the case where the violence is a threat rather than an actual assault, or the injury is psychological as RIDDOR only applies to physical injuries.

It should be remembered that just because an incident does not need to be reported in line with the RIDDOR regime, it does not mean it is not capable of being the subject of an HSE investigation nor does it fall outside the responsibility of employers as set out in health and safety legislation by way of general duties under the Health and Safety at Work Act 1974 or the requirements for the assessment of risk etc within the Management of Health and Safety at Work Regulations 1999.

An assault on a member of staff would ordinarily be the subject of a criminal investigation by the police who would liaise with the Crown Prosecution Service as to whether there was sufficient evidence to prosecute an offender and whether it was in the public interest to do so. The existence of such an investigation would not preclude a parallel investigation, usually by the Health and Safety Executive, where it was felt that underlying management failures might have contributed to staff not being protected from violent incidents.

The police deal with the investigation of the actual crime and the HSE consider whether the systems of work or the actual workplace played some role in either encouraging the violence or there was a failure to protect an employee from attack. The issues are likely to be very different. Certainly the HSE guidance to inspectors is to focus on the management of violence rather than to duplicate the parallel police investigation.

There has been a series of guidance notes issued directly to the NHS⁵. In addition HSE guidance has been published in relation to violence in the workplace for particular types of employment. The Health Services Advisory Committee appointed by the Health and Safety Commission publishes 'Violence and Aggression to Staff in Health Services – Guidance on Assessment and Management'.

This sets out detailed guidance on risk assessment as well as measures that might be considered in designing the workplace with a view to minimising the risk of violent attack. These range from ensuring that there are enough seats for people to sit on and minimising the level of noise to

installing alarms and panic buttons and ensuring that furniture and decoration are not easily converted into weapons. Effective measures are not just about the physical environment, the effective training of staff in dealing with difficult service users and in breakaway techniques is also important to ensure the issue of workplace violence is properly addressed. In addition, new qualifications relating to the handling and management of workplace violence have recently been launched.

Whilst HSE guidance is not compulsory and additional measures can be implemented, it should be recognised that if an incident is investigated by an HSE Inspector, the investigation will refer to the relevant published guidance. If it is felt that the guidelines were not implemented and that



not all 'reasonably practicable' steps had been taken to reduce or minimise the risk of violence in the workplace, the employer could face criminal, and/or civil liability. In contrast, being able to illustrate systems of assessment, audit and practice would substantially assist in illustrating that an employer had taken all reasonably practicable steps in a situation where, notwithstanding those efforts, a member of staff had been subjected to a violent attack.

¹ 'Violence at Work: Findings from the 2002/2003 BCS'

² 'A Safer Place to Work: Protecting NHS Hospital Staff from Violence and Aggression' – March 2003

³ The NHS Zero Tolerance Campaign, "Working Together: Securing a Quality Workforce for the NHS"; and "Improving Working Lives".

⁴ Rv John Stephen Paul McNally (1999) CA

⁵ "Dealing with Harassment by NHS Service Users – A guide for NHS Managers" September 2002 and "The Managers Guide – Stopping Violence Against Staff Working in the NHS" October 2002

Neglect in the Coroners Courts

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Two House of Lords cases this year (Middleton and Sacker) have provided further clarification on the boundaries within which Coroners can both direct juries and give verdicts. The question in issue related to how the Inquest process complied with Article 2 of the Human Rights Act, which states that there is a right to life. In the absence of a criminal trial or Public Inquiry, an Inquest is the primary method of the state fulfilling its requirement under Article 2. The House of Lords considered how far reaching the Inquest process should be and what verdict should be available.

The matter at issue centres upon how compatible Article 2 of the Human Rights Act is with Rule 36 of the Coroners Rules. Rule 36 governs the matters to be determined at an Inquest and provides that the evidence shall be directed solely to ascertaining: (a) who the Deceased was; and (b) how, when and where the Deceased came by his death. The Courts have previously narrowly interpreted rule 36.

The Court of Appeal considered the matter in the case of Jamieson [1995] and determined that 'how' meant 'by what means' not 'in broad circumstances'. Accordingly the verdict could provide a brief factual statement but expressed no opinion or judgment.

As to neglect, the Court found that a neglect verdict would only be justified in the most extreme circumstances, going well beyond ordinary negligence, to be found to have contributed to the Deceased taking his own life. Furthermore, where there was neglect it should not be referred to in a verdict unless there was a direct causal link between it and the death. The effect was that neglect cases have been rare.

The House of Lords considered the matter further in the case of Middleton and found that the Inquest process did not always meet the investigative obligation of Article 2. Consequently Jamieson was overturned and the scope of inquiry was widened. They determined that 'how' now means not only 'by what means' but also 'in what circumstances'. However there should continue to be no finding of criminal liability and in respect of civil liability 'neglect' should be avoided.

The House of Lords determined that whilst a traditional short form verdict may sometimes be enough it often will not. Narrative verdicts and verdicts given in answer to the Coroner's questions may now be given and consequently the Jury can express their conclusions on the facts more explicitly.

This is relevant to PCTs who may be concerned that their performance will be scrutinised and criticised during the course of an Inquest in view of the fact the distinction between 'individual neglect' and 'systemic neglect' no longer exists. PCTs can adopt a number of measures to protect themselves from such criticisms. If there has been a systems failure, the PCT should be able to demonstrate how it has learnt from this, including what systems have been put in place to rectify that failure and how staff have been retrained. The PCT may also have to provide evidence as to whether similar incidences have previously occurred. This may require evidence from senior management being given to the Coroner.

Furthermore, the clinicians attending the Inquest should be fully prepared and know what to expect in giving evidence. This includes giving careful consideration to the witness statements to be provided to the Coroner.



A right to treatment

Christopher Malla Partner, Healthcare Department



The Judgment in *R (Burke) v General Medical Council (GMC)* (30.07.04) sets out the common law and European Jurisprudence relating to medical consent and the right to treatment of patients who either have or lack capacity. Mr Justice Munby's Judgment focuses on the end of life decisions and, specifically, the circumstances in which it is lawful for doctors to withhold or withdraw artificial nutrition and hydration (ANH).

There is little new law contained in the Judgment, although it clarifies the existing law and shifts the emphasis to a patients' positive 'right to treatment', as opposed to the negative 'right to die'.

Facts

The Claimant, Oliver Leslie Burke suffers from a congenital degenerative brain condition, spino-cerebellar ataxia that will eventually result in an inability to swallow and a need for ANH. He is likely to retain full cognitive faculties until his death is imminent and will be aware of the pain and extreme distress that would result from dehydration and malnutrition.

The Claimant did not want ANH withdrawn until he died of natural causes. He did not want to die of thirst and did not want doctors deciding that his life was no longer worth living and withdrawing ANH.

The Claimant sought declarations that the withdrawal of ANH leading to death by starvation or thirst would breach his rights under the European Convention of Human Rights and unlawful under domestic law. He also argued that elements of the GMC Guidance 'Withholding and Withdrawing Life – Prolonging Treatments: Good Practice in Decision Making' was unlawful insofar as it failed to protect a patient's right to life and treatment.

Withdrawal of ANH: A positive duty to treat

In his Judgment Munby J reaffirmed that once a patient is admitted to hospital a duty arises to provide treatment that is in the patient's best interests. An evaluation of best interests involves a welfare appraisal in the widest sense, taking into account, where appropriate, a wide range of ethical, social, moral, emotional and welfare considerations. The best interest test is not restricted to medical factors. A doctor's opinion will only be determinative in respect of medical best interests. When a doctor is assessing best interests the starting point is the Bolam test. Is the treatment within a range of treatments that would be accepted by a responsible body of medical practitioners? Where there is a choice between Bolam compliant treatments only one will be in the patient's best interests.

If a patient is competent (or, although incompetent, has made an advance directive, which is both valid and relevant to the treatment in question) the patient has the right to decide what is in his best interests. The patient is the ultimate arbiter. Munby J stated "his decision as to where his best interests lie, and as to what life prolonging treatment he should or should not have, is in principle determinative. Important as a sanctity of life is, it has second place to personal autonomy".

If the patient lacks capacity and has no advance directive either the doctor or the Court must decide what is in the patient's best interests. Munby J stated that the 'starting point' in relation to withholding or withdrawing of life prolonging treatment 'must be the very strong presumption in favour of taking all steps which will prolong life'. In case of doubt, that doubt falls to be resolved in favour of the preservation of life. He did, however, acknowledge that this obligation was not absolute and the sanctity of life may have to take second place to human dignity. He considered the touchstone of best interests in the context of withdrawing or withholding life-prolonging treatment to a patient without capacity is 'intolerability'. He is of the view that 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.

Once a patient has, however, reached the final stages of his illness and collapsed into a coma it would not be unlawful if ANH is withdrawn in circumstances where it is serving absolutely no purpose, save the very short prolongation of life of a dying patient who lacks all awareness. He considered that continuation of ANH in such circumstances would be futile.

Convention Rights

Munby J also considered the interaction between Article 2 (right to life), Article 3 (prevention of inhuman or degrading treatment) and Article 8 (protection of personal autonomy) of the European Convention for the Protection of Human Rights. He considered, as with the common law, that sanctity of life took second place to personal autonomy and a patient's Article 8 rights prevailed over the rights in Articles 2 and 3. He confirmed that:

- A competent patient has the right to accept or refuse ANH. Articles 2 and 3 do not compel anyone to force life-prolonging treatment if the patient refuses to accept it. To do so would breach a patient's right of autonomy under Article 8.
- A Trust's failure to provide life-prolonging treatment to an incompetent patient, which exposes the patient to acute mental and physical suffering will be a breach of Article 3.
- Articles 2, 3 and 8 will not be breached if ANH is withdrawn in the final stages of an incompetent patient's illness when he has collapsed into a coma and has lost all sense of awareness.

When is Court approval required?

Munby J sets out guidance as to when prior Court authorisation is required, as a matter of law, when withholding or withdrawing ANH:

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

Compelling a doctor to treat

Munby J acknowledged a doctor cannot be required to undertake treatment he does not, in his clinical judgment, wish to provide. He

accepted the Court will not grant a mandatory order requiring an individual doctor to treat a patient. A doctor cannot decline to continue treating a patient merely because his views as to what is in the patient's best interests differ from those of the patient or the Court.

A doctor has a continuing duty of care to find someone else to assume the responsibility of the patient and he 'cannot lawfully shed that responsibility unless arrangements are made for the responsibility to be taken over by someone else'.

GMC Guidance

Munby J, whilst considering the GMC Guidance to be commendable, criticised the Guidance in four respects:

- Its emphasis was too much on the right to refuse treatment, rather than the right to require it.
- Fails to sufficiently acknowledge that it is the duty of the doctor who is unable or unwilling to carry out the wishes of the patient to go on providing the treatment until he can find another doctor who will do so.
- Fails to acknowledge the heavy presumption in favour of life-prolonging treatment and to recognise that the touchstone of best interests is intolerability.
- Fails to spell out the legal requirement to obtain prior judicial sanction for the withdrawal of ANH.

Guidance for the future

Whilst the GMC has indicated that it is appealing the Judgment it is unlikely that any Appeal will detract from the principles of law set out by Munby J. Whilst we await the outcome of any appeal PCTs should:

- Ensure clinicians appreciate the patient's choice of legitimate options for treatment is determinative even if not the clinicians' first choice.
- Have arrangements in place to transfer care to another clinician or another Trust or PCT if there are irreconcilable differences between patient and clinician.
- Ensure clinicians understand the wide scope of the 'best interests' test and be reminded of the strong presumption in favour of preservation of life and the intolerability test which should be applied when assessing a patient's best interests.
- Ensure arrangements are in place to seek Court declarations in the circumstances set out above.
- Review local policies, drafted under the GMC Guidance and take into account the criticisms raised by Munby J.

Whilst there is little new law in the Judgment it is a masterly exposition of the common and European law of medical consent and provides clear guidance on the withholding and withdrawing of ANH to patients who have or lack capacity. The outcome of any Appeal is awaited.

Bed-blocking – how PCTs could be affected

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In 2003 it was estimated that on any single day up to 4,000 patients were occupying beds on acute wards when they could be better cared for elsewhere. This was because they were waiting for a decision on what type of continuing care they needed, or for that care to be made available. Usually NHS and Social Services staff work closely to ensure that patients move to appropriate care as soon as possible but in some cases delays occur because Social Services are slow to assess patients or cannot provide the care services that the patient needs in order to leave hospital.

The Government has been tackling this problem of 'bed-blocking' in two ways: firstly by increasing funding for Social Services and secondly by giving the NHS new powers in the Community Care (Delayed Discharges etc) Act 2003 ('the Act'). This article explores the Act from a PCT's point of view.

How the Act works

The Act applies to both NHS Trusts and PCTs. The patients covered by the Act are those receiving acute care for which they are not paying. However various types of care do not count as 'acute care' under the Act, notably:

- Palliative care
- Care provided for the purposes of recuperation or rehabilitation
- Intermediate care
- Mental health care
- Maternity care

The Act enables a Trust to compel Social Services to assess what care services a patient will need when he/she is discharged from hospital by serving a formal notice upon the Local Authority responsible for the area where the patient is usually resident. Social Services are then under a duty to assess the patient's needs and identify the care services which should be made available for the patient and/or his/her carer so that it will be safe to discharge the patient from hospital. They must consult the hospital so that a decision can be taken about which services (if any) Social Services will make available. The Trust is under a corresponding duty to consult with Social Services and consider what care services (if any) the NHS should provide in the community for that patient.

If Social Services are to provide care services for the patient and/or his carer then the Trust must give Social Services formal notice of the day on which it proposes to discharge the patient from hospital.

If the patient cannot be discharged on the arranged date because Social Services have not carried out an assessment, or have failed to provide services as promised, the Local Authority must pay the Trust a fixed sum of money (currently £100, or – £120 in some areas) for each day that discharge is delayed for either of these reasons.

When can a PCT use the Act?

- If a PCT runs a hospital which admits patients for acute care then it can use the Act to help prevent bed blocking in that hospital due to delays caused by Social Services.
- However if a PCT runs facilities which provide rehabilitation, palliative care, intermediate care or other types of care excluded from the definition of 'acute care' then the Act cannot be used in respect of patients in those facilities.

In practice there will probably be few occasions when a PCT can use the Act to address the problem of bed-blocking.

How could the Act affect PCTs?

If an acute Trust uses the Act to facilitate the discharge of a patient, PCT staff may become involved in the assessment process; or the PCT may agree to provide continuing care services, perhaps in conjunction with Social Services.

It is worth remembering that:

- A notice to assess a patient's care needs cannot be served upon a PCT or other NHS body even if it is likely that the NHS will provide all the continuing care which the patient requires.
- An acute Trust cannot claim delayed discharge payments from a PCT or other NHS body even if the delay in discharging a patient is caused wholly or partly by a failure by the NHS to play its part in the assessment process or in providing continuing care services.

Nevertheless one can imagine that acute Trusts and Social Services will be looking to PCTs to co-operate fully and swiftly with the assessment process and the provision of care services to ensure that patients are discharged on time and delayed discharge payments do not become payable.

Also, if a PCT and a Local Authority have a pooled budget, it could be used to pay any delayed discharge payments which the Local Authority is liable to make. It is up to the PCT and the Local Authority to agree whether the pooled budget may be used for this purpose and, if so, the PCT will probably want this potential liability of the Local Authority to be taken into account when fixing the respective contributions to the budget.

Time will tell how much use is made of the Act and PCTs may not encounter it directly. However it is necessary to be aware of its scope, not least because there may be increasing pressure on PCTs, from acute Trusts and Local Authorities, to help provide a rapid response to any bed-blocking crisis.