COMMENTARY

TOEING THE LINE (OR DOING A DELICATE DANCE?): THE COURTS AND THE CLINICIANS

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ABSTRACT

This comment responds to the comment by Jonathan Youngs in *St George's Healthcare NHS Trust v P*¹ entitled 'Can the courts force the doctor's hand?' Vol. 24, No. 1, pp. 99–111, doi: 10.1093/medlaw/fww042. It clarifies an important factual error in that comment as to the nature of the order made by the court, and it provides further observations upon the respective role of courts and clinicians in cases involving medical treatment decisions.

KEYWORDS: Best interests decisions, Jurisdiction of the court, Medical treatment decisions

In his comment upon *St George's Healthcare NHS Trust v P*² entitled 'Can the courts force the doctor's hand?',³ Jonathan Youngs suggested that Newton J had gone beyond the conventionally accepted boundary between the courts and clinical professionals by ordering doctors to provide renal replacement therapy ('RRT') to a patient lacking capacity. The essential thrust of his argument was that, in so doing, Newton J had breached the so-called 'Re J principle'⁴ that the court cannot compel medical professionals to provide treatment contrary to their professional judgement.

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1 [2015] EWCOP 42

2 [2015] EWCOP 42

3 Medical Law Review, Vol. 24, No. 1, pp. 99–111, doi: 10.1093/medlaw/fww042.

4 After the decision in *Re J (A Minor) (Child in Care: Medical Treatment)* [1993] Fam.15, CA.

The comment was, unfortunately, based upon a false premise—albeit one that was entirely understandable given the terms of the judgment, given that Newton J stated that he ‘order[ed] and direct[ed] that the renal replacement should continue’.⁵ However, as is now clear,⁶ the material part of the order made by the court—embodying the actual decision of the court⁷—was a declaration that it was ‘lawful, being in [P]’s best interests, for [P] to continue to receive renal replacement therapy’.⁸

It might be said that such a declaration infringed (albeit indirectly) the *Re J* principle by suggesting that the converse was true, ie that it would be unlawful for P not to continue to receive RRT in circumstances where P’s treating clinicians considered that to provide such treatment was against their professional judgement. However, on a proper analysis, this is not correct either. It is vitally important to understand that, by coming to court for so-called ‘best interests declarations’,⁹ the treating Trust implicitly represented that

1. RRT was on offer and would remain on offer;
2. the court therefore had to decide on P’s behalf and in his best interests¹⁰ whether to continue to consent to the provision of RRT;
3. if the court decided on P’s behalf to continue to consent to the provision of RRT, RRT would continue to be administered.

That Newton J did so decide (albeit that he recorded his decision in the form of a declaration rather than a decision¹¹) should not therefore be seen as a judge doing anything improper.

Rather, the lesson of this case—at least from the perspective of a legal practitioner—is that it is crucial that there is clarity *before* any application is made as to whether:

5 [2015] EWCOP 42 at para. 45.

6 Following publication of the comment (which represented views that were also shared by at least some other medical professionals), the present author contacted the clerk to Newton J to clarify precisely what had happened. Newton J in turn agreed to the publication of the anonymised order. There is nothing improper in such approaches being made—and, as the present case shows—such may in some circumstances be necessary to resolve clear misunderstandings which may develop an unfortunate life of their own.

7 Applying conventional principles, which apply also in the Court of Protection: see *Re X (Court of Protection Practice)* [2015] C.O.P.L.R. 582, CA.

8 Although not stated expressly, this must have been a declaration made under s.15(1)(c) Mental Capacity Act 2005 (MCA 2005), which provides that the court may make declarations as to ‘the lawfulness or otherwise of any act done, or yet to be done, in relation to [the] person [the subject of the proceedings]’.

9 There is, in fact, no such thing: s 15(1)(c) MCA 2005 ‘does not confer any general power to make bare declarations as to best interests; it is very precise in defining the power in terms of declarations as to “lawfulness”’: *Re MN (An Adult)* [2015] C.O.P.L.R. 532, CA at para. 89 per Sir James Munby P.

10 Under s.16(1)(1)(a) MCA 2005. Section 16(3) MCA 2005 makes express that the powers of the court are subject to the provisions of (inter alia) s.4, ie that decisions made on behalf of P must be made in their best interests.

11 Sir James Munby P regretted in *Re MN* (footnote 8) the ‘still inveterate use of orders in the form of declaratory relief [which] might be thought to be in significant part both anachronistic and inappropriate’ (para. 88). It should be noted that Practice Direction 9E accompanying the Court of Protection Rules and amplifying procedure in serious medical treatment cases is likely to be amended in due course to make clear that—as a general rule—the primary relief to be granted by the Court will be a decision on P’s behalf to consent (or refuse to consent) to the medical treatment in question.

1. the treating clinicians have reservations as to whether continuing (or where relevant providing) the treatment would be in P's best interests,¹² but they are prepared to do so;¹³ or
2. the treating clinicians consider that to continue (or to provide) the treatment would be to act in a way contrary to their professional clinical judgement.¹⁴

If the latter, it is *strongly* suggested that bringing an application on the basis that the court is being asked to determine where P's best interests lie is simply wrong. Indeed, as suggested by Moylan J in *Re L*,¹⁵ where there are no treatment options available, the court has no effective choice to make on P's behalf, and it is the court (rather than the clinicians) which is being put in an impossible position if the application is brought for a decision as to where P's best interests lie.¹⁶

If the treating Trust considers that their clinicians need to have legal 'cover' for a decision to withdraw or withhold treatment,¹⁷ then the application should either be brought in the Queen's Bench Division for a declaration under Part 8 of the Civil Procedure Rules or in the Court of Protection for a declaration under s.15(1)(c) MCA 2005.¹⁸ On such an application, the Trust can—and should—expect that there will be '*rigorous probing* [and] *searching questions*'¹⁹ as to why particular treatment options are not available, along with '*persuasion*'²⁰ on the part of the court, especially if it appears that the decisions of the clinicians as to whether to offer particular treatments are being influenced by value judgements as to the quality of the patient's life.²¹ Nor will a court—being bound by s.6 Human Rights Act 1998—grant a declaration as to lawfulness if it considers that to do so would, itself, be to act incompatibly with the patient's rights under the ECHR.²²

12 'Best interests' here being 'best interests' in its wide MCA sense, as characterised by Lady Hale in *Aintree University Hospitals NHS Foundation Trust v James* [2014] A.C. 591 at para. 39.

13 Or the Trust can identify other clinicians who would be prepared to provide such treatment.

14 Including—potentially—where to do so would be to incur resources disproportionate to the benefit to the individual patient.

15 *An NHS Trust v L, FL and TL* [2013] C.O.P.L.R. 558, COP, at para. 113.

16 In *Re L*, Moylan J was deeply dissatisfied at being essentially forced into what he regarded—rightly—as being an 'empty' best interests decision where, in reality, there were no treatment options available, but no party was prepared to advance a case to the effect.

17 As the Court of Appeal observed in *R (Burke) v General Medical Council (Official Solicitor and others intervening)* [2006] Q.B. 273, the court has no power to authorise what which would otherwise be unlawful (or vice versa), whether by reference to the criminal or common law. "*Good practice may require medical practitioners to seek such a declaration where the legality of proposed treatment is in doubt. This is not, however, something that they are required to do as a matter of law*", see paras 71 and 80.

18 But making very clear that the treating Trust considers that the relevant treatment is not available in the sense characterised above.

19 *Re MN (An Adult)* (note 8) at para. 81.

20 *Ibid.*

21 The importance of valuing the patient's own assessment of the quality of their life has recently been strongly emphasised by Peter Jackson J in *Wye Valley NHS Trust v B* [2015] EWCOP 60. See also, by analogy, and for the perspective of families, the discussion in A Morris, 'Selective Treatment of Irreversibly Impaired Infants: Decision-Making at the Threshold' (2009) 17 *Med Law Rev* 347, 376.

22 See *MN* (note 8) at paras 41 and 42, and *Local Authority X v MM (By the Official Solicitor) and KM* [2009] 1 F.L.R. 443.

It is clear, however, that judges of the Court of Protection are careful to respect the dividing line between—and the respective expertise of—the judiciary and clinicians. Whilst the steps set out above may appear to be unduly formalistic, they are vitally important so as to ensure that applications are brought in such a way as to enable judges clearly to identify where that dividing line lies in any given case. As the *St George's* case makes clear, the price of not doing so can be high.