RadcliffesLeBrasseur

September 2004

HEALTH LAW REVIEW BULLETIN

Doctor's acquittal overturned

Are the new Council's powers unfair?

What can be more stressful in a doctor's career than having to attend a conduct hearing before the General Medical Council? Not much. So if a doctor faces a hearing before the Professional Conduct Committee but is acquitted of serious professional misconduct, can he breathe a sigh of relief and put it behind him? Not any more. Welcome to the new regulatory world!

The Council for the Regulation of Healthcare Professions ('the Council') is the new overarching body which examines the work of nine regulatory organisations including the General Medical Council (GMC), the General Dental Council and the Nursing and Midwifery Council. Its powers emanate from the National Health Service and Health Care Professions Act 2002 ('the Act').

Section 29(4) of the Act allows the Council to refer decisions of the disciplinary committees of the nine regulatory bodies concerned to the High Court if it considers that the decision was *'unduly lenient ... and .... it would be desirable for the protection of members of the public'*. The policy behind this is to provide some mechanism to 'appeal' an over-lenient decision, just as a practitioner can appeal against a decision which is too severe. However, it was envisaged by John Hutton MP who introduced the Bill that *"....the power will need to be used only in exceptionally rare circumstances"*.

What Mr Hutton did not make clear is whether or not it was intended that the power of the Council should extend to cases in which practitioners have been acquitted, as opposed to being sentenced too leniently after conviction.

The Council's own consultation paper questioned whether the Council had the power to refer acquittals. It noted in particular that the list of relevant decisions set out in s.29(1) did not sit easily on this point as this suggests that the Council can only refer those decisions made after a finding of serious professional misconduct. The Council happily concluded that *'however that matter is resolved, it should not affect many cases which are likely to be of concern'*. As it so happens, the very first case to be referred by the Council involved precisely this issue.

RadcliffesLeBrasseur were instructed by the Medical Protection Society in this first case challenging the remit of the Council's new powers. This article summarises the difficulties in assessing the scope of the Council's powers and the potential impact (and injustice) they may have on health care professionals.

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Seminar - Recent Developments in Healthcare Law

A seminar will be held on Wednesday 6 October 5.00 p.m. to 6.30 p.m.
Topics to be covered include:

- Claims
- Quantum
- Inquests
- Regulatory matters

Places are limited so early booking is recommended.

For further information please contact
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Doctor's acquittal overturned continued

Disciplinary hearing

In October 2003, Dr Ruscillo attended a disciplinary hearing before the Professional Conduct Committee of the GMC on a charge of serious professional misconduct. It was alleged that he had had an affair with a patient. As the GMC had been investigating the case for nearly 18 months, it was surprising that the prosecution did not take the opportunity of calling any witnesses at the hearing. Dr Ruscillo was acquitted.

The Council then sought to appeal against this decision, despite the well established principle in English law that there is no general right of appeal against an acquittal. Our firm advice was to resist the appeal, foremost on the grounds of double jeopardy, but also on the basis that as an appeal against acquittal it arguably fell outside the powers conferred on the Council by s.29 of the Act.

High Court decision

The question whether the Council has the power to appeal against an acquittal by the Professional Conduct Committee of the GMC was considered as a preliminary issue in the case by the High Court. As this was the first appeal of its kind, there was (and still is) a lack of regulation and guidance for those involved. The case is therefore of utmost importance for setting a precedent for future cases.

The judge came to the view that it was the intention of Parliament to provide the Council with the widest powers to oversee each of the regulatory body's activities. Finding against Dr Ruscillo, he held: -

- The Council does have the power to appeal an acquittal to the High Court under s.29 of the Act.

- The decision of the disciplinary committee concerned does not have to be wrong. An appeal may succeed on the basis that the committee was not presented with important evidence at the hearing which, if adduced, might have led to a different result.

RadcliffesLeBrasseur's view

These findings raise serious issues. Not only does it open the door for double jeopardy, but the judge is effectively also saying that if the prosecution for the GMC fails to produce relevant evidence, then this is a valid ground of appeal. If the Council is allowed to appeal the decision, then Dr Ruscillo will have to face the same charges again. Defendants are normally protected from this by law.

We have no objection to the new powers given to the Council, so long as they are used appropriately. However, if the ruling is left intact, there are dire implications for health care professionals who have been acquitted.

If the Council does not like the outcome of a disciplinary hearing, it can appeal it. Likewise, if it does not like the outcome of a second hearing, it can appeal that as well. There may be no limit to the number of retrials which could potentially take place. In our opinion, this is manifestly unfair and potentially an abuse of process.

The case continues…

We lodged an appeal and the hearing before the Court of Appeal has now taken place; the Court has reserved judgment. We await this in the hope that the Court of Appeal will agree with our views - watch this space!

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Hilda Pearson

Life prolonging treatment

Challenge to the GMC's guidance

The High Court has recently declared in the case of R *(On the Application of Burke) v The General Medical Council* that key sections of the General Medical Council's guidance on withdrawal of life prolonging treatment are unlawful. The case has given added legal force to the fundamental right that it is the individual who primarily determines how he should die.

The facts

The claimant, Leslie Burke, suffers from cerebellar ataxia, a progressively degenerative disorder that follows a similar course to multiple sclerosis and will necessitate artificial nutrition and hydration (ANH) as his condition worsens. Eventually, he will lose the ability to swallow. Thereafter, he will only survive if he is fed through a tube. Mr Burke was concerned with the wording of guidelines issued by the GMC entitled *'Withholding and Withdrawing Life Prolonging Treatments: Good Practice and Decision Making'*. His worry was that the emphasis throughout is on the right of the competent patient to refuse treatment rather than his right to require treatment.

Legal principles

The case was pleaded under articles 2 (right to life), 3 (prohibition against inhuman and degrading treatment) and 8 (right to a family life) of the European Convention on Human Rights (ECHR), incorporated in English law by the Human Rights Act 1998. Once a patient is admitted to a NHS hospital a duty of care arises to provide treatment, notwithstanding that the patient is competent or incompetent, conscious or unconscious. The doctor and the hospital are then under a continual obligation that cannot lawfully be shared unless arrangements are made for someone else to take over the responsibility. The duty to care is to be carried out pursuant to what is in the best interests of the patient.

New guidance from judgment

The judgment confirms that sections of the GMC's guidance on the withdrawal of life prolonging treatment are unlawful. It provides comprehensive instructions and guidance on correct and lawful procedures for a doctor treating a patient in an analogous situation to that of Mr Burke. It also confirms that health professionals must do as much as possible to preserve life and that there should not be a different approach to a less able or incompetent patient. It includes the following points: -

- The evaluation of a patient's best interests involves a welfare appraisal in the widest sense, taking into account, where appropriate, ethical, social, moral, and emotional considerations.
- Doctors can claim no special expertise on the many non medical matters. Medical opinion can never be determinative of what is in a patient's best interests.
- It is for the patient, if competent, to determine what is in his own best interests. If the patient is incompetent and has left no binding and effective advance directive then it is for the Court to decide what is in his best interests.
- The right of self determination and dignity are fundamental rights protected by Articles 3 and 8 of the ECHR. Article 8 embraces such matters as how one chooses to pass the closing days and moments of one's life and how one manages one's death. Dignity interests protected by the ECHR include the preservation of mental stability, the right to die with dignity, and the right to be protected from treatment or from a lack of treatment, which will result in a patient dying in avoidably distressing circumstances.
- An enhanced degree of protection is called for under Articles 3 and 8 in the case of the vulnerable.
- Treatment is capable of being degrading, whether or not there is awareness on the part of the patient.
- Failure to provide life prolonging treatment in circumstances exposing the patient to 'inhuman or degrading treatment' will in principle involve a breach of Article 3. For example, there will be a prima facie breach of

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Life prolonging treatment continued

Article 3 if care is removed in circumstances where this will subject him to acute mental and physical suffering and lead to him dying in unavoidably distressing circumstances.

- If the patient is competent (or although incompetent has made an advance directive which is both valid and relevant to the treatment in question) 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. The sanctity of life takes second place to personal autonomy.

- The personal autonomy protected by Article 8 means that in principle it is for the competent patient, and not his doctor, to decide what treatment should or should not be given.

- If the patient is incompetent, the test is best interests. There is a very strong presumption in favour of taking all steps which will prolong life. In the context of life prolonging treatment the touchstone of best interests is intolerability. 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.

Withdrawal of ANH

The judgment concluded as follows on the specific question of withdrawing ANH:-

- If the patient is competent (or, although incompetent, has made an advance directive which is both valid and relevant to the treatment in question) his refusal to accept ANH is determinative. Similarly, his decision to require the provision of ANH which he believes is necessary to protect him from what he sees as acute mental and physical suffering is also determinative.

- Withdrawal of ANH, in contravention of a patient's wishes, before the claimant finally lapses into a coma would involve clear breaches of Articles 3 and 8 as it is clear that the patient would be exposed to acute mental and physical suffering.

- The position of an incompetent patient is likely in practical terms to be the same. Thus, if ANH provides some benefit it should be given unless the patient's life, if thus prolonged, would subjectively be intolerable.

- Where it is proposed to withhold or withdraw ANH the prior authorisation of the Court is required in certain circumstances. For example: where there is evidence that the patient when competent would have wanted ANH to continue in the relevant circumstances; where there is evidence that the patient resists or disputes the proposed withdrawal of ANH; and where persons entitled to have their views taken into account assert that withdrawal of ANH is contrary to the patient's wishes or not in the patient's best interests.

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Promotions

RadcliffesLeBrasseur has promoted six lawyers in its Healthcare Department.

In our London office, Ian Sadler has become a Partner, and the three new Associates are Alexandra Johnstone, Yvonne Screene and Paul Thomson.

In our Leeds office, Clare Chapman and Ian Cooper have been appointed Associates.

If you require any further information regarding the issues mentioned in this bulletin, please contact info@rlb-law.com

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