

**IN THE SUPREME COURT OF JUDICATURE  
IN THE COURT OF APPEAL (CIVIL DIVISION)  
ON APPEAL FROM THE QUEEN'S BENCH DIVISION  
CROWN OFFICE LIST  
MR JUSTICE LAWS**

Royal Courts of Justice  
Strand  
London WC2A 2LL  
10 March 1995

B e f o r e :

**THE MASTER OF THE ROLLS  
(SIR THOMAS BINGHAM)  
THE PRESIDENT  
(THE RT HON STEPHEN BROWN)  
LORD JUSTICE SIMON BROWN**

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**R E G I N A**

**-v-**

**CAMBRIDGE HEALTH AUTHORITY  
EX PARTE "B" (A Minor)**

**Appellant**

**Respondent**

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MR N PITT (Instructed by Mills & Reeve, Cambridge, CB2 1PH) appeared on behalf of the Appellant.

MR B MCINTYRE (Instructed by Sharpe Pritchard, agents for Kerseys, Ipswich IPI 3HD) appeared on behalf of the Respondent.

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**MASTER OF THE ROLLS:** This is an application for leave to appeal (and if granted an appeal) against a decision of Laws J. The case has been listed under the title "Ex parte B" and the court has made a direction under section 39 of the Children and Young Persons Act 1933 that nothing be published which leads to the identification of the minor involved in the case. The reasons for that order will be quite obvious as I summarise the facts. I would supplement the formal order of the court by a special plea to those involved in reporting this matter that, so far as possible, the case be reported in such a way that it will not only prevent identification of the child but prevent even the child herself realising that she is the subject of the report. The reason for saying that is that the child is desperately ill to an extent that she herself would not appreciate. Nothing could be more tragic than that she should, by reading a newspaper or watching the television, learn even indirectly of her

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The order which is the subject of appeal is an order of certiorari quashing a decision of the Cambridge Health Authority not to fund any further treatment of the child involved in this case by way of chemotherapy and a second bone marrow transplant.

B is a child now aged 10½. In September 1990 it was first diagnosed that she was suffering from what is technically known as non-Hodgkins lymphoma ("NHL") with common acute lymphoblastic leukaemia ("ALL"). This was treated with chemotherapy over a period of months. In August 1992 that course of chemotherapy treatment was completed, for the time being successfully.

Unhappily, the successful treatment did not endure. In December 1993 the child developed acute myeloid leukaemia ("AML") and was treated for the second time with a course of chemotherapy. On this occasion she underwent a course of total body irradiation, a fact of some importance since it appears to be accepted by medical opinion that that is treatment which no-one can undergo more than once.

In March 1994 B underwent a bone marrow transplant. Again, for a substantial period of months there was every reason for her family to hope and believe that the transplant had been successful. Unhappily that turned out not to be so. In January this year she suffered a further relapse of acute myeloid leukaemia. It is that relapse that has given rise to the present proceedings.

At all times B's family, and in particular her father, have strained every nerve to procure for her the best possible treatment. They have always had, as one would expect, her best interests at the very forefront of their minds. The father has deposed that when this further relapse took place he consulted doctors at Addenbrooke's Hospital in Cambridge, including Dr Broadbent, the doctor who had treated B over the years since 1990. At that stage Dr Broadbent's medical judgment was that the child had a very short period of some six to eight weeks to live and that no further treatment could usefully be administered.

Other doctors who had had the care of B at earlier stages (in particular two doctors at the Royal Marsden Hospital in London, one of whom had performed the bone marrow transplant in March 1994) were consulted, who shared the opinion of Dr Broadbent; the respondent Authority was invited to allocate funds for the treatment of B. The treatment involved was potentially a further course of chemotherapy which, in this case, would be a third course. If that was successful, and only if successful, that would be followed by a second bone transplant operation.

B's father was unwilling, and understandably reluctant to accept the views expressed by Dr Broadbent and others. He approached doctors in the United States. Certain doctors there differed from the view which had been expressed by the English doctors and thought that there was a substantial chance of

the United States does not come free and does not come cheap. The cost of treatment by these experts in the United States was, at least to English eyes, prohibitive. B's father accordingly sought help from additional doctors in this country. In particular he approached a notable expert in this field. Professor Goldman of the Hammersmith Hospital, a Professor at the Royal Postgraduate Medical School.

We have two letters of 14 and 17 February written by Professor Goldman to Dr Pinkerton of the Royal Marsden. In his letter of 14 February, Professor Goldman wrote, having summarised briefly the further relapse which had overtaken B:

"I had a long discussion with the father about possible options for further therapy. In essence I agreed with the alternatives that you set out. The compromise that I thought might be reasonable would be to offer the patient further chemotherapy with the hope of achieving a complete remission. A reasonable combination might be MAE [and I omit the chemical names for which that is an abbreviation] because this should not involve excessive additional cardiotoxicity. If complete remission could be achieved, then one might contemplate a second transplant, either with the original sibling donor or conceivably with a matched unrelated donor. I rank the chance of success with this approach as less than 20 per cent."

In his letter of 17 February, Professor Goldman wrote, having had the benefit of a discussion with the consultant paediatrician at the Royal Marsden, that:

"I stand by my view that it would be reasonable to give [B] further chemotherapy with cytotoxic drugs in the hope of achieving complete remission. I realise of course that this may not succeed but I regard it as the best palliative approach to a patient with acute myeloid leukaemia in relapse after bone marrow transplantation, whatever the age of the patient.

If the patient were fortunate enough to achieve complete remission, one could contemplate a second transplant procedure. Obviously this is a high risk strategy and one would need to think very carefully about approaches designed to prevent relapse on a second occasion. This however would not be a totally impossible task. This second transplant could in certain circumstances be carried out at the Hammersmith Hospital in London.

If a decision to give further chemotherapy now were accepted, the issue arises as to where this might take place. I understand that neither you [that is Dr Mellor] nor Dr Broadbent in Cambridge is keen to undertake further treatment of this nature. We would do so at the Hammersmith but iust at present we have

available within the next 2-3 weeks. In these circumstances, I have no option but to suggest to [the father] that he seeks treatment in the private sector. I know for example that Dr Peter Gravett would treat [B] with extreme efficiency and with some luck, a second remission could be achieved."

The officer of the respondent Authority with responsibility for contracting for the purchase of medical and surgical services outside his Health Authority is a highly qualified physician named Dr Zimmern. On 21 February he wrote to B's father recording that he had spent much of the day in detailed discussions with colleagues about B's care, including discussions with Professor Goldman. He said he understood totally the father's concerns and the sense of distress which he must feel. He added:

"Should there be any misunderstanding I should state quite clearly that any decision taken by the [Authority] will be made taking all clinical and other relevant matters into consideration, and not on financial grounds.

The [Authority] has funded, and continues to fund, bone marrow transplantations. The [Authority] is also supportive of second, and in difficult cases, third opinions and is grateful to have had the benefit of Professor Goldman's opinion from the Hammersmith following her out-patient consultation, which we understand was arranged by yourself. Dr Broadbent confirms that she subsequently sent a fax to Professor Goldman, at your behest, outlining [B's] clinical condition. I understand from Professor Goldman that his opinion was subsequently sent to Dr Pinkerton and Dr Mellor at the Marsden and to Dr Broadbent at Addenbrooke's. I have had the benefit of seeing that correspondence and of noting Professor Goldman's views. He has subsequently confirmed to me that the line of treatment that he indicated might be a possibility for [B] was at variance with majority opinion and would be properly categorised as experimental rather than standard therapy."

The next paragraph is a reference to the policy of the Marsden not to perform second bone marrow transplants. Dr Zimmern continued:

"At present no formal request for funding has yet been made to the [Authority] from any hospital, but I should like to emphasise that any decision on this issue will be taken in the light of all the clinical advice available to it in the context of DOH guidance on the funding of unproven or experimental treatments, at all times with [B's] best interest in mind.

At this stage, I have to say that on the evidence provided to us it is unlikely that we will authorise further intensive chemotherapy for B but will always keep under review the nature of the clinical

Having received the advice which I have described from Professor Goldman, B's father then communicated, as was proposed, with Dr Gravett. Dr Gravett wrote a long letter dated 23 February expressing the view that, so far as the chemotherapy was concerned, the chances of obtaining a complete remission in the circumstances were, in his judgment, 10 - 20 per cent. He acknowledged that it would be impossible to repeat the irradiation treatment again and indicated that the initial chemotherapy might cost about £15,000 and, if the bone marrow transplant stage was reached, a further £60,000. In paragraph 5 he referred to a fax which he had received from Professor Goldman and expressed the view that if the family and the patient agreed that the treatment which was proposed had a worthwhile chance of success he was willing to give it. In the result, the Authority, the respondents, through Dr Zimmern, maintained their refusal to fund further chemotherapy.

In a letter of 27 February 1995 Dr Zimmern has made the Authority's position clear. He wrote to Dr Gravett:

"You have been extremely frank within your letter in your assessment of the prognosis of the treatment which you propose to offer and have confirmed that the treatment is of an experimental nature. You have also made it clear to me that prognosis in the case of secondary AML is worse than that of the primary variety. You confirmed that your own Unit at the London Clinic would not be able to take children of [B's] age and that you propose to carry out the treatment at the Portland Clinic. You were also able to tell me that you had discussed the case with [B's] paediatrician, Simon Mellor, and was conversant with his opinion that [B] should not undergo a second BMT.

Given your assessment, together with the advice that I have received from [B's] medical advisers at both Addenbrooke's and the Marsden, and in view of DOH guidance on the funding of treatment not of a proven nature, I regret that my [Authority] is unwilling to fund this treatment."

It was the contents of that letter, which were communicated to B's father, which prompted the present application for judicial review.

Before the learned judge and before us there are several affidavits sworn by B's father. They exhibit a certain amount of learned medical material, the opinions of the American doctors and a certain amount of the correspondence from the English doctors who were willing, in principle, to undertake this treatment. On the Authority's side, there were three sworn affidavits. The first of these is sworn by Dr Broadbent, the physician who has had the responsibility for treating B since her illness was first diagnosed. She describes her state of mind in paragraph 3 of her affidavit:

"I have considered very carefully whether a second allogeneic

considered the prospects of success and the suffering which [B] would undergo as a result of such treatment. First [B] would have to undergo a course of intensive chemotherapy with the hope of achieving a complete remission. Such chemotherapy would in itself cause considerable suffering. Only if complete remission could be achieved could a second allogeneic transplant be considered. In fact a complete remission is unlikely to be achieved. Further, the prospects of a second transplant being successful are only in the region of 10 per cent. I took the view that it would not be right to subject [B] to all this suffering and trauma when the prospects for success were so slight."

In paragraph 4 she describes:

"...any further definitive treatment by way of intensive chemotherapy or a second transplant as being treatment of an experimental nature rather than for the genuine therapeutic needs of [B]."

There is an affidavit sworn by Dr Pinkerton of the Royal Marsden. He also expresses the opinion that a further course of intensive chemotherapy with a view to a second possible transplant operation would not be appropriate. He expresses the judgment that the chances of a successful outcome would be slight, only in the region of 10 per cent. He believed that a course of palliative therapy would be in the best interests of B and said:

"This would enable her to enjoy several weeks or months of normal life prior to progression. A further course of intensive chemotherapy and a second transplant would mean several uncomfortable and distressing weeks or months in hospital which in all probability [B] would not survive."

He concluded at paragraph 4:

"This is a very sad case and I fully understand [the father's] endeavours to do everything possible for the sake of his daughter. However, I remain of the view that it would not be in [B's] best interest to subject her to a distressing course of treatment which is most unlikely to be successful and carries a high risk of early morbidity."

Finally, an affidavit was sworn by Dr Zimmern. He refers to the opinions which he had obtained from Dr Broadbent, Dr Mellor and Dr Pinkerton. He also referred to the American opinions which had been expressed, to his discussions with Professor Goldman and his exchanges with Dr Gravett. He summarised his conclusions in these paragraphs which are sufficiently important to justify quotation:

"First and foremost I had to consider whether the proposed course of treatment was clinically appropriate for [B]. I also had to consider whether it would be an effective use of the [Authority's] limited resources, bearing in mind the present and future needs of other patients. The opinions of Dr Broadbent, Dr Pinkerton, Professor Goldman and Dr Gravett were broadly similar as to the prospect of a successful outcome, I also noted that Professor Goldman had agreed that the proposed treatment could and would be described as experimental. In other words, he agreed with Dr Broadbent, Dr Pinkerton and Dr Mellor that the treatment could not be justified purely on therapeutic grounds and that the fundamental justification would be experimentation. I attached great weight to the clinical judgment of Dr Broadbent who had been treating [B] ever since her first referral in September 1990 at the age of 5 years. I also attached great weight to the clinical judgment of Dr Pinkerton who had carried out the first bone marrow transplant operation. Having considered all the medical opinions put before me I decided to accept the clinical judgment of Drs Broadbent, Pinkerton and Mellor that a further course of intensive chemotherapy with a view to a second transplant operation was not in the best interests of [B].

I have also been influenced in my decision by the consistent advice and directions of the Department of Health with regard to the funding of treatments which have not been proven to be of benefit. The ethical use of resources demands that new and expensive treatments are evaluated before they are transferred to the NHS for service funding. The doctors to whom I spoke were consistent in their advice that the proposed treatment was neither standard nor had been formally evaluated.

I also considered that the substantial expenditure on treatment with such small prospect of success would not be an effective use of resources. The amount of funds available for health care are not limitless. The Respondent has a responsibility to ensure that sufficient funds are available from their limited resources for the provision of treatment for other patients which is likely to be effective."

In the course of his judgment quashing the decision of the Authority, the learned judge made four criticisms of the manner in which the Authority had reached its decision. Before I turn to those, however, it is important that I should state very clearly, as the judge did, that this is a case involving the life of a young patient and that that is a fact which must dominate all consideration of all aspects of the case. Our society is one in which a very high value is put on human life. No decision affecting human life is one that can be regarded with other than the greatest seriousness.

The second general comment which should be made is that the courts are not, contrary to what is sometimes believed, arbiters as to the merits of cases of this kind. Were we to express opinions as to the likelihood of the effectiveness of medical treatment, or as to the merits of medical judgment, then we should be straying far from the sphere which under our constitution is accorded to us. We have one function only, which is to rule upon the lawfulness of decisions. That is a function to which we should strictly confine ourselves.

The four criticisms made by the learned judge of the Authority's decision were these. First, he took the view that Dr Zimmern as the decision maker had wrongly failed to have regard to the wishes of the patient, as expressed on behalf of the patient by her family, and in particular by her father. Our attention was directed to the affidavits that I have mentioned. The point was made that nowhere does one see an express statement that among the factors that led Dr Zimmern to his decision was a consideration of the wishes of the family. In that situation, the learned judge held that the Authority had failed to take a vitally important factor into consideration and that the decision was accordingly flawed.

I feel bound for my part to differ from the judge. It seems to me that the learned judge's criticism entirely fails to recognise the realities of this situation. When the case was first presented to the Authority, it was presented on behalf of the patient, B, as a case calling for the cooperation and funding of the Authority. At all times Dr Zimmern was as vividly aware as he could have been of the fact that the family, represented by B's father, were urgently wishing the Authority to undertake this treatment; by "undertake" I of course mean provide the funding for it. He was placed under considerable pressure by the family and, in the first instance, perhaps unfortunately, made reference to his policy of not corresponding directly with patients or their relatives about what he called "extra-contractual referrals", meaning requests for the purchase of medical services outside the Health Authority.

The inescapable fact is, however, that he was put under perfectly legitimate, but very obvious, pressure by the family to procure this treatment and he was responding to that pressure. It was because he was conscious of that pressure that he obviously found the decision which he had to make such an agonising one and one calling for such careful consideration. To complain that he did not in terms say that he had regard to the wishes of the patient as expressed by the family, is to shut one's eyes to the reality of the situation with which he was confronted. It is also worthy of note, and there is no hint of criticism in this, that the accusation that he did not take the patient's wishes into account was not made in the grounds annexed to Form 86A. It was not, therefore, recognised as an accusation calling for a specific rebuttal.

The second criticism that is made is of the use of the expression "experimental" to describe this treatment. The learned judge took the view, and Mr McIntyre on behalf of B urges, that that is not a fair or accurate

a worthwhile chance of success. The fact, however, is that even the first course of treatment had a chance of success of something between 10 and 20 per cent. It was only if, contrary to the probabilities, that was totally successful, that it would be possible to embark on the second phase of the treatment which itself had a similar chance of success.

The plain fact is that, unlike many courses of medical treatment, this was not one that had a well tried track record of success. It was, on any showing, at the frontier of medical science. That being so, it does not, in my judgment, carry weight to describe this decision as flawed because of the use of this expression.

The third criticism that is made by the judge is of the reference to resources. The learned judge held that Dr Zimmern's evidence about money consisted only of grave and well rounded generalities. The judge acknowledged that the court should not make orders with consequences for the use of health service funds in ignorance of the knock-on effect on other patients. He went on to say that "where the question is whether the life of a 10year old child might be saved by however slim a chance, the responsible Authority. . . . must do more than toll the bell of tight resources". The learned judge said: "They must explain the priorities that have led them to decline to fund the treatment", and he found they had not adequately done so here.

I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make. In my judgment, it is not something that a health authority such as this Authority can be fairly criticised for not advancing before the court.

Mr McIntyre went so far as to say that if the Authority has money in the bank which it has not spent, then they would be acting in plain breach of their statutory duty if they did not procure this treatment. I am bound to say that I regard that submission as manifestly incorrect. Unless the Health Authority had sufficient money to purchase everything which in the interests of patients it would wish to do, then that situation would never ever be reached. I venture to say that no real evidence is needed to satisfy the court that no Health

I furthermore think, differing I regret from the judge, that it would be totally unrealistic to require the Authority to come to the court with its accounts and seek to demonstrate that if this treatment were provided for B then there would be a patient, C, who would have to go without treatment. No major Authority could run its financial affairs in a way which would permit such a demonstration.

The fourth criticism which the learned judge made was that the Authority had wrongly treated the problem which they faced as one of spending £75,000 when, in the first instance, the treatment only involved the expenditure of £15,000. It was therefore a two stage process, so it was held and submitted to us, and not a one stage process as the Authority wrongly thought. Again, I regret that I differ from the judge's view. It is of course true that if the first stage were unsuccessful, then £15,000, or even less than £15,000, would be the maximum that the Authority would end up spending. It would not, however, be reasonable for the Authority to embark on this expenditure on that basis since, quite plainly, they would have to continue if, having expended the £15,000, it proved successful and the call for the second stage of the treatment came. It was, therefore, an inescapable decision whether they should embark on this process at all. Having weighed the matter up and taken advice, particularly bearing in mind the suffering which even embarking on the treatment would inflict, the Authority thought that they should not fund the treatment at all. I regret that I find it impossible to fault that process of thinking on their part.

Such is my sympathy with the father and B herself that I have been tempted, although disagreeing with the judge's reasoning, to leave the order which he made in being and invite the Authority to reconsider the matter in the light of the judge's conclusions. I have, however, concluded that that would be a cruel deception since I would be bound to make clear that, in my judgment, the Authority could, on a proper review of all the relevant material, reach the same decision that they had already reached and I would feel obliged, expressly, to dissociate myself from the learned judge's opinion that it would be hard to imagine a proper basis upon which this treatment, at least its initial stage, could reasonably be withheld. In my judgment, it would be open to the Authority readily to reach that decision since it is, as I think, the decision they have already reached.

While I have, as I hope is clear, every possible sympathy with B, I feel bound to regard this as an attempt, wholly understandable but nonetheless misguided, to involve the court in a field of activity where it is not fitted to make any decision favourable to the patient.

THE PRESIDENT: After the most critical, anxious consideration, I feel bound to say that I am unable to say that the Authority in this case acted in a way that exceeded its powers or which was unreasonable in the legal sense. The powers of this court are not such as to enable it to substitute its own

who have heard it, particularly those who have to take some part in deciding issues concerned with it, must be aware of the gravity and anxiety which attaches to the making of such a decision. I find myself in agreement with the decision which the Master of the Rolls has already given and I therefore agree that the appeal should be allowed.

**LORD JUSTICE SIMON BROWN:** For reasons given by my Lords, I too grant the appeal.

**ORDER:** Appeal allowed. **Legal Aid taxation of the appellant's costs.**