Cardiopulmonary resuscitation and human rights – recent developments

Introduction

Until 2016 it was commonplace for doctors to withhold cardiac massage from patients whom they thought would not benefit from it; either through not surviving the procedure or considering life post-procedure as being too burdensome for them to bear. This decision was often made without reference to either the patient or their relatives, even when the patient was able to understand the implication of such a decision. Two cases from 2014 and 2015 signalled that this paternalistic behaviour was contrary to the patient's human rights. This essay contends that the resulting increase in scope of the patient's right to respect for privacy has actually created a new right for the patient's relatives; a right which has only illusory benefits for the patient. The unintended consequence of this has been to make it more likely that the patient themselves will suffer in the last moments of life. A brief overview of the medical issue is followed by a closer look at the two cases in question and the human rights consequences of the judgements.

Cardio-pulmonary Resuscitation (CPR)

CPR 'is a violent and invasive physical treatment used to attempt … to re-start the heart if possible. It involves repeated forceful compression of the bare chest … attempted inflation of the lungs by forcing air or oxygen into the lungs … the injection of drugs into veins or into bones and the delivery of high-voltage electric shocks.'[1] The technique was understood as far back as 1878 [2] but its use did not become widespread until Kouwenhoven's seminal paper of 1960.[3] It is now a globally used technique with defibrillation machines installed in towns and cities for public use.[4] Life support courses are mandatory for all health care staff working in the UK with many courses offered free to the public.[5]

[1] *R (Tracey) v Cambridge University Hospitals NHS FT* [2014] EWCA Civ 822 [10]

[2] Boehm R, 'Ueber wiederbelebung nach vergiftungen und asphyxie' (1878) 8 Archives of Experimental Pathology and Pharmacology 68

[3] Kouwenhoven WB, Jude JR, Knickerbocker GG, 'Closed chest cardiac massage' (1960) 173 Journal of the American Medical Association 1064

[4] Defibrillation machines located in the UK can be found using the website < http://www.heartsafe.org.uk/AED-Locations> accessed 2nd March 2017

[5] CPR courses for the public can be found using the website <www.bhf.org.uk/heart-health/how-to-save-a-life/how-to-do-cpr/heartstart>accessed 2nd March 2017

Of course, 'forceful compression of the bare chest to a depth of 5-6 centimetres'[6] is not without hazard. The Resuscitation Council suggest that rib and sternal fractures occur in over 90% of all patients over the age of 70 who undergo the procedure.[7] Other injuries include liver, spleen and stomach rupture, pneumothorax as well as internal haemorrhage. In a small number of cases the CPR actually contributed to death. This burden must be weighed against the benefit of CPR.

The National Cardiac Arrest Audit has been running for over a decade.[8] In the period 2015-16 it collected data on over 16,000 CPR events in participating UK hospitals. Approximately 80% of all patients undergoing CPR in hospital did not survive until discharge although in more than half of all CPR recipients a circulation was temporarily restored. The major two characteristics of those who did survive were: relative youth and a cardiac rhythm that was amenable to electrical defibrillation. Hence, for elderly patients found to have an arrest rhythm not amenable to defibrillation, the survival rate was closer to 10%. This is comparable to the 2% - 12% survival to discharge rate of patients suffering cardiac arrest outside of a hospital.[9] On first inspection this makes trained hospital arrest teams appear no more effective than concerned passers-by. However, the two patient groups are very different. The passer-by is more likely to be confronted by a younger patient with a rhythm amenable to defibrillation. The hospital arrest team will be dealing with a patient already ill enough to be admitted to hospital and probably undergoing treatment for something other than a heart problem; the heart has stopped as an end-point to the underlying disease. Simply restarting the heart makes no difference to the prospect of survival to discharge for most in-patients.

Putting the benefit and burden together, it is clear that most patients who undergo CPR suffer rib or sternal fractures and most do not survive. Hence, there are a considerable number of patients who spend their last hours and minutes being traumatised with no prospect of ever leaving hospital.

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[6] *R (Tracey) v Cambridge University Hospitals NHS FT* [2014] EWCA Civ 822 [10]

[7] Eduard Kralj, Matej Podbregar, Natasa Kejzarc, Joze Balazic 'Frequency and number of resuscitation related rib and sternum fractures are higher than generally considered' (2015) 93 Resuscitation 136

[8] Key Statistics from the National Cardiac Arrest Audit 2015/16 < www.resus.org.uk/research/national-cardiac-arrest-audit/> accessed 2nd March 2017

[9] Perkins GD, Brace-McDonnell SJ, 'The UK Out of Hospital Cardiac Arrest Outcome (OHCAO) project' (2015) British Medical Journal < http://bmjopen.bmj.com/content/5/10/e008736> accessed 2nd March 2017

In the hospital setting there are three measures which, when properly applied, ensure that such traumatic deaths are reserved for those who may have benefitted. First there is consent, second there is best interests and third futility.

Consent

Of the three checks and balances, consent is probably the least contested and easiest to understand. A person not consenting to CPR might ordinarily have a claim in battery.[10] However, in the peculiar setting of cardiac arrest, implied consent and necessity may both play a role in defence of such a claim.[11] If no explicit decision has been made in advance about CPR and the express wishes of a person are unknown and cannot be ascertained, there should be an initial presumption that healthcare professionals will make all reasonable efforts to resuscitate the person in the event of cardiac or respiratory arrest.[12]

A patient with capacity is also in a position to decline CPR. In other words the presumption of consent to allow CPR can be rebutted by the patient themselves.

As explored later, implied consent can only be meaningful if the purpose of the implication is to allow benefit to follow. If the CPR deliverer knows the procedure will not deliver any benefit then it is argued that this extinguishes implied consent and renders the CPR a battery.

Best interests

Best interests, in the medical setting, are matters of importance to an individual patient which can be protected or harmed by the medical team. The Mental Capacity Act 2005 (MCA) provides a statutory guide to best interests and is unequivocal about when the concept is to be applied and when it is of no consequence.[13] Section 1(4) allows patients with mental capacity the right to make 'unwise decisions' so that best interests only applies to 'a person who lacks capacity'.[14] Hence,

[10] *Collins v Wilcock* [1984] 3 All ER 374

[11] Resuscitation Council (UK) 'The legal status of those who attempt resuscitation '2015 <www.resus.org.uk/cpr/legal-status-of-those-attempting-cpr/> accessed 2nd March 2017

[12] British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (previously known as the 'Joint Statement') 'Decisions relating to cardiopulmonary resuscitation' (2016) 3rd edition (1st revision) page 17

[13] Mental Capacity Act 2005

[14] S.1(5) Mental Capacity Act 2005

prior to cardiac arrest a person is free to decline CPR for whatever reason. The occasional patient actually has 'DNACPR' (Do Not Attempt Cardio-Pulmonary Resuscitation) tattooed on their chest. Whilst this would seem to a healthcare professional conclusive evidence of the patient's refusal to allow CPR it fails to meet the strict criteria required of a valid advanced decision; it is merely evidence.[15]

Section 2(1) MCA states:

> For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Hence, the arrested individual lacks capacity and the decision to give or withhold CPR, absent any valid advanced decision by the patient or court order, is based on best interests.[16]

Lady Hale elaborated on the MCA concept of 'best interests' in her leading judgement in *Aintree:*

> The starting point is the strong presumption that it is in a person's best interests to stay alive.[17] In considering the best interests of a particular patient at a particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude is or would be likely to be; and they must consult others who are looking after him or interested in his welfare.[18]

Futility

Futility, as a concept, makes no appearance in the MCA and has been subject to much debate since medical paternalism has ceded to patient autonomy.[19] 'Futile', to have any meaning, requires reference to a goal which is either unachievable or, at best, very unlikely to be achieved.

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[15] Ss 24-26 Mental Capacity Act 2005. An advance decision is not applicable to life-sustaining treatment unless the decision is verified by a witnessed, written statement by the patient to the effect that it is to apply to that treatment even if life is at risk.

[16] S.15 Mental Capacity Act 2005.

[17] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 [35]

[18] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 [39]

[19] M Nair-Collins 'Laying Futility to Rest' (2015) 40 *Journal of Medicine and Philosophy* 554; DJ Wilkinson, J Savulescu 'Knowing when to stop: Futility in the intensive care unit' (2011) 24 *Current Opinion in Anaesthesiology* 160; A Halevy, B A Brody 'A multi-institution collaborative policy on medical futility' (1996) 276 *Journal of the American Medical Association* 571

The prospective nature of such a reference point demands some degree of certainty. Retrospectively, anything that did not work was futile; it is the degree of prospective utility, either non-existent or negligible, that gives meaning to futility. Lady Hale defined futile as treatment 'being ineffective or being of no benefit to the patient'[20] as opposed to the Court of Appeal's version stating that treatment is futile unless it has 'a real prospect of curing or at least palliating the life-threatening disease or illness from which the patient is suffering'.[21] Lady Hale's version of futility might be viewed as 'physiologic futility'; the most proximal aim of the activity is almost certain to fail.[22]

Hence, for a doctor to withhold CPR on the grounds of physiologic futility she must first properly address the most proximal goal of the activity. This is not rendering a patient to a state of health that doctor would find tolerable; that may be impossible even before CPR is required. This is a best interests question, not one of futility. CPR is only futile when it simply will not summon a 'return of spontaneous circulation' (ROSC). The representative for the Disability Rights Commission drew a clear distinction in *Burke*: 'When considering whether life-saving treatment should be given or continued, three separate questions have to be answered. First, whether the contemplated treatment is futile; second, whether it is in the best interests of the patient and third, whether resources should be deployed to provide it.' [23]

Contra-indications to CPR

Futility can be regarded as a moral contraindication to any medical procedure since it risks harm, wastes limited resources and delivers no benefit. In "Hippocratic" terms, the cardinal rule of 'first do no harm' has been broken.[24] To be lawful there must be an honestly held belief in consent and a public interest in the activity.[25] It would be hard to argue, for a healthcare professional at least,

[20] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 [40]

[21] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 [43]. It is this version of futility which has generated the intense criticism to the very use of the word 'futile' in a medical setting.

[22] LJ Schneiderman, NS Jecker, AR Jonsen 'Medical futility: Its meaning and ethical implications '(1990) 112 *Annals of Internal Medicine* 949

[23] *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, [2006] QB 273 [285]

[24] Daniel K Sokol '"First do no harm" revisited' [2013] BMJ <www.bmj.com/content/347/bmj.f6426> accessed 2nd March 2017.

[25] *Attorney-General ref no 6 1980* [1981] QB 715

that a patient would consent to a 90% chance of broken ribs with no prospect of living beyond the duration of the CPR. Where is the public interest component? Clearly, the healthcare provider must have knowledge of futility for this to apply. Often there is doubt and the 'strong presumption that it is in a person's best interests to stay alive' imperative applies.[26] Nevertheless, a healthcare provider 'going through the motions' on a dying patient in the belief that futility is not a bar to CPR is probably guilty of battery at best or an offence against the person at worst.[27]

Advanced decisions prohibit a person from delivering CPR but in practice these are rarely seen outside the blood transfusion directives held by Jehovah's Witnesses.[28] They are so infrequently encountered that when they do appear doctors are guided by their professional body to be very suspicious of the document.[29] If the clinician has doubts as to the document's validity or applicability (even if the decision is actually valid and applicable) she can ignore it.[30]

No formal mention of human rights has yet been made; an essential component to any legal discussion surrounding life and death decisions. For the purposes of this essay the right to life, privacy and freedom from inhuman treatment are the focus of attention.

Human Rights

Article 2

A number of Articles of the ECHR are pivotal when considering CPR. Firstly, there is Article 2 (1): Everyone's right to life shall be protected by law. As with most of the Articles of the Convention several questions are spawned by the statement. If a life is lost does this mean the state has failed to protect it? Clearly, case law is required to examine the scope of this absolute right.

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[26] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 [35]

[27] Offences Against the Person Act 1861

[28] Clinician familiarity with such specific advanced decisions from this particular group is well established and has wide support throughout the medical community. See, for instance, the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee website <www.transfusionguidelines.org/transfusion-handbook/12-management-of-patients-who-do-not-accept-transfusion/12-2-jehovah-s-witnesses-and-blood-transfusion> accessed 9th March 2017

[29] General Medical Council 'Treatment and care towards the end of life' (2010). Section 70**: '**Assessing the validity of advance refusals', offers 7 paragraphs of checks and section 71: 'Assessing the applicability of advance refusals' offers 4 further checks.

[30] General Medical Council 'Treatment and care towards the end of life' (2010). Section 73 'Doubt or disagreement about the status of advance refusals'.

The first important message from Article 2 cases is that the burden of protection is on the state, not the individual; it is not an inter-individual obligation. However, an individual acting (or omitting) on behalf of the state can trigger an action. In *Osman*, which revolved around the state's obligation to protect others from criminal activity, a measure of practical reality helped limit the scope of the Article:

> For the Court … the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Accordingly, not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising.[31]

In *Savage* the issue regarded the state's obligation under Article 2 to prevent suicide in hospitals.[32] Lord Rodger said 'it has long been recognised that a state's positive obligations under article 2 to protect life include a requirement for hospitals to have regulations for the protection of their patient's lives.[33]

Hence, in order to carry out its state devolved obligations to patients suffering from cardiac arrest, a hospital should have suitably trained personnel and operational policies to ensure life is protected. It follows that hospitals have a positive duty to deliver CPR to patients who suffer cardiac arrest. Does this duty extend to even those patients with no prospect of surviving beyond the duration of the CPR? The patient is still alive until such time as their artificially supported circulation ceases.[34] Again, case law helps avoid this unsupportable situation.[35]

Munby's expansive Court of Appeal comments in *Burke* received both positive and negative comments in the Lords. His position on 'dying' was approved:

> Article 2 does not entitle anyone to continue with life-prolonging treatment where to do so would expose the patient to 'inhuman or degrading treatment' breaching article 3.[36]

However, Lord Philips cautioned:

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[31] *Osman v UK* (1998) ECHR 101 [116]

[32] *Savage v South Essex NHS Trust* [2008]UKHL 74, [2009] 1 AC 681

[33] *Savage v South Essex NHS Trust* [2008]UKHL 74, [2009] 1 AC 681 [44]

[34] J Oram, P Murphy 'Diagnosing death' (2011) 11(1) *Continuing Education in Anaesthesia, Critical Care & Pain* 77

[35] Eventually there would be more people requiring round the clock CPR than would be available to deliver it.

[36] *R (Burke) v General Medical Council* [2004] EWHC 1879 (Admin) , [2005] QB 424 [162]

> 'It does not … lead to the further conclusion that if a National Health doctor were deliberately to bring about the death of a competent patient by withdrawing life-prolonging treatment contrary to that patient's wishes, article 2 would not be infringed. It seems to us that such conduct would plainly violate article 2. Furthermore, if English law permitted such conduct, this would also violate this country's positive obligation to enforce article 2.[37]

Nevertheless, the appeal court agreed with Munby J where '[h]e said …"where the patient is dying, then the goal may properly be to ease suffering and, where appropriate, to 'ease the passing' rather than to achieve a short prolongation of life." [38] This accords with Lord Goff's position in *Bland*:

> [T]he law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end.[39]

In conclusion, a doctor may stop CPR in order to safeguard the patient's Article 3 rights but not to bring about death. This 'dual effect', of providing or withdrawing treatment for one purpose but accepting that another effect is likely, has been considered before and affords doctors some latitude when acting for their patients.[40]

The corollary of this is that a doctor need not start CPR if it is futile or the patient is dying. One might go further and say that a doctor *must* not start CPR if it is futile or the patient is dying. On this point the case law discussed below has suggested otherwise.[41]

Article 8

Article 8 (1) of the ECHR states that: 'Everyone has the right to respect for his private and family life, his home and his correspondence.' The first two rights (private and family life) are also seen in the United Nation's 'Universal Declaration of Human Rights' (UDHR) and the 'International

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[37] *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, [2006] QB 273 [39] Lord Phillips

[38] *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, [2006] QB 273 [63]

[39] *Airedale NHS Trust v Bland* [1993] UKHL 17, [1993] AC 789 [866]

[40] Quoting Lord Donaldson, Butler-Schloss LJ said: 'What doctors and the court have to decide is whether…a particular decision as to medical treatment should be taken which *as a side effect* will render death more or less likely.' *Airedale NHS Trust v Bland* [1993] UKHL 17, [1993] AC 789 [819]

[41] *Winspear* and *Tracey* as discussed later

Covenant on Civil and Political Rights' (ICCPR); clearly, the principle has an international dimension. It is these first two rights which need to be observed in the context of DNACPR.

Article 8 (1) sits with 8 (2) which confers the right to interfere with these rights 'in accordance with the law, to meet a legitimate aim' and 'as is necessary in a democratic society.' Such interference must be proportionate but there may be legitimate differences between how one country interprets this compared with another.[42] A 'margin of appreciation' and a degree of 'judicial deference' is allowed in order to recognise that not every country has the same social, moral and cultural reference points.[43] Hence, the right to a private and family life is a qualified right, not an absolute one.

The two cases which follow have taken Article 8 a little beyond that which was possibly intended when the Article was first envisaged.[44] This is not a phenomenon unique to Article 8 but is a product of the 'living instrument' doctrine seen in Human Rights law.[45] Rights are intended to be 'practical and effective' rather than 'theoretical or illusory'.[46]

Family life has a broad definition[47] and where a relationship is not encompassed by 'family' it can slip under the umbrella of 'private'. The MCA, in its guidance on whom to consult to determine best interests, refers to 'anyone named by the person as someone to be consulted on the matter in question or on matters of that kind', and 'anyone engaged in caring for the person or interested in his welfare'.[48] Practically, with mentally incapacitated patients, the MCA is the point of reference when deciding who represents 'family'.

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[42] *R (Daly) v Secretary of State for the Home Department* [2001] UKHL 26

[43] *Handyside v UK* (1976) EHRR 737

[44] *Winspear* and *Tracey* as discussed later

[45] *Tyrer v UK* (1978) 2 EHRR 1. The Court held that Tyrer being birched by the police represented 'degrading treatment' contrary to the Article 3 of the European Convention on Human Rights. Whilst this may have been acceptable in the past the law (and rights) should move with the times.

[46] 'The Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective' *Airey v Ireland* (1979) 2 EHRR 305 [24]

[47] Loveday Hodson 'A Marriage by Any Other Name? Schalk and Kopf v Austria' [2011] 11 (1) *Human Rights Law Review* 170

[48] Mental Capacity Act 2005 4 (7) a) and b)

Private life has been given a very wide definition by the ECtHR, so much so that it is not capable of 'exhaustive definition'.[49] When Diane Pretty took her case to the ECtHR the court said that 'the very essence of the Convention is respect for human dignity and human freedom'. [50]

The court possibly did not appreciate that the judicial development of Article 8 would pit 'dignity' *against* 'freedom' and generate a new right for 'family' against the subject's right to dignity. In practical terms, it is argued that this is exactly what has happened.

Tracey

A case was brought against Cambridge University Hospital by the estate of Janet Tracey claiming, *inter alia*, that the Trust had violated her Article 8 rights by failing to consult with her or members of her family about a DNACPR notice put in her case notes.[51] The case took the form of a judicial review. Essentially, a doctor had come to the conclusion that because Janet Tracey had advanced lung cancer and had subsequently suffered major trauma following a road traffic accident, performing CPR would offer no clinical benefit. It is not clear whether this was understood to be due to futility (in the narrow sense we have already examined) or simply unlikely to secure life for more than a few hours; a best interests issue. It was the fact that neither she nor her family were engaged in the DNACPR decision which troubled the court. There was no dispute that the doctor was correct in his clinical assessment of the utility of CPR; the *process* was considered faulty not the 'substantive decision to withhold CPR'.[52]

Contained within the judgement by Dyson MR were points which deserve scrutiny.

Firstly:

> [A] decision to deprive the patient of potentially life-saving treatment is of a different order of significance for the patient from a decision to deprive him or her of other kinds of treatment.[53]

For an individual patient, CPR might not be 'potentially life-saving'. As we have discovered, CPR cannot reasonably be considered life-saving if life is only preserved for the duration of the CPR. This is not a best interests question which is, by its nature, subjective. Futility is entirely objective

[49] *Peck v UK* (2003) ECHR 44

[50] *Pretty v UK* (2002) ECHR 427

[51] *R (Tracey) v Cambridge University Hospital NHS FT* [2014] EWCA Civ 822, [2015] 1 QB 543

[52] *R (Tracey) v Cambridge University Hospital NHS FT* [2014] EWCA Civ 822 [43] Dyson MR

[53] *R (Tracey) v Cambridge University Hospital NHS FT* [2014] EWCA Civ 822 [55] Dyson MR

if Lady Hale's definition is used. If there is no return of circulation, and no prospect of it, then discussion is academic. The right to a private life becomes 'theoretic and illusory' and not 'practical' or 'effective' if CPR would be futile.[54]

Secondly:

Lord Dyson went on to say: 'The fact that the clinician considers that CPR will not work means that the patient cannot require him to provide it.'[55] This begs the question as to what purpose is served by telling the patient that they will not receive a particular treatment on the grounds that it is of no benefit? Should a patient with tonsillitis be told that they will not be given a liver transplant? A liver transplant has no function in the treatment of tonsillitis in the same way that CPR has no function in a patient whose heart cannot be restarted.

Thirdly:

An entirely reasonable defence argument offered by Lord Pannick touched on compassion; a doctor faced with futility might spare a patient the distress of telling them that CPR will not be attempted.[56] Lord Dyson accepted that distress might be caused but the patient should only be spared this if it was 'likely to cause the patient a degree of harm'.[57] This implies that distress is not in itself harmful. Longmore LJ elaborated by suggesting that only distress which 'would likely cause the patient to suffer physical or psychological harm' would be unreasonable to inflict.[58] Simply scaring a patient out of their wits shortly before death would, by this reasoning, be a reasonable insult to inflict. Few health care professionals are likely to subscribe to this rather cold position.

A note of caution, again in the interests of compassion, was sounded by the Chairman of the Resuscitation Council who feared that:

> [A] judgment which states (or implies) that there is a presumption that, save in exceptional cases, every DNACPR decision must be made after consultation with the patient would

[54] 'The Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective' *Airey v Ireland* (1979) 2 EHRR 305 [24]

[55] *R (Tracey) v Cambridge University Hospital NHS FT* [2014] EWCA Civ 822 [55] Dyson MR

[56] *R (Tracey) v Cambridge University Hospital NHS FT* [2014] EWCA Civ 822 [46]

[57] *R (Tracey) v Cambridge University Hospital NHS FT* [2014] EWCA Civ 822 [56] Dyson MR and [93] Longmore LJ

[58] *R (Tracey) v Cambridge University Hospital NHS FT* [2014] EWCA Civ 822 [96] Longmore LJ

> seriously hamper the ability of health care professionals to provide individualised and compassionate care for vulnerable people towards the end of their lives.'[59]

Longmore LJ was exercised by this 'well-balanced and powerful intervention'[60] and even referred to Lord Phillips salutory warning in *Burke* that the court might 'enunciate propositions of principle without full appreciation of the implications that these will have in practice'. [61] Despite this the court decided that unless discussions were either impracticable or actionably harmful then patients must be engaged in DNACPR decisions otherwise article 8 would be breached. No distinction was drawn between best interests and futility; a key distinction which was also ignored in *Winspear. Winspear* increased further the scope of Article 8 by insisting that family are consulted if the patient themselves lacks capacity.

Winspear

Winspear was resumed pending the result of the *Tracey* case and turned a right for the subject into a right for the subject's family.[62] Here, a patient without capacity was involved.[63] The subject also had serious long-standing medical issues and CPR was considered to be a therapy which would be a futile exercise causing nothing but discomfort and distress in the last few moments of his life. Blake J said '[t]here is nothing in the *Tracey* case or the Strasbourg case law to suggest that the concept of human dignity applies any the less in the case of a patient without capacity.'[64] This seems entirely reasonable. He went on:

> [T]he MCA spells out when and with whom a decision taker must consult; if it is not practicable or appropriate to consult a person identified in section 4 (7) before the decision is made or acted on, then there would be a convincing reason to proceed without consultation.'[65]

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[59] *R (Tracey) v Cambridge University Hospital NHS FT* [2014] EWCA Civ 822 [92]

[60] *R (Tracey) v Cambridge University Hospital NHS FT* [2014] EWCA Civ 822 [92] Longmore LJ

[61] 'The danger is that the court will enunciate propositions of principle without full appreciation of the implications that these will have in practice, throwing into confusion those who feel obliged to attempt to apply those principles in practice' *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, [2006] QB 273 [21] Lord Phillips

[62] *Winspear v City Hospitals Sunderland* [2015] EWHC 3250, [2016] QB 691

[63] Mental Capacity Act 2005 Section 2 (1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

[64] *Winspear v City Hospitals Sunderland* [2015] EWHC 3250 [45]

[65] *Winspear v City Hospitals Sunderland* [2015] EWHC 3250 [46]

This applies to best interests; the Act even prefaces this section with such a title. The Act does not mention 'futile' (in the sense of useless) in any section. This is a crucial point which the judge failed to fully appreciate.

The defendant doctor in the *Winspear* case declined the opportunity to call Carl Winspear's mother in the middle of the night. Blake J said 'I can see every reason why a telephone call at 3 am may be less than convenient or desirable than a meeting in working hours, but that is not the same as whether it is practicable.'[66] Regarding appropriateness, the doctor felt that the DNACPR decision was entirely clinical and the mother's opinions would make no difference. This was roundly rebutted:

> 'It is not a debate about clinical judgment … [r]ather it is to communicate the decision to ... the patients carer, so that important medical decisions about treatment are taken with relevant input into the decision making process, the principle of dignity and best interests is respected in the widest sense and the family can take on board and respond to the news. [The] carer does not have a veto over the treatment plan but she is entitled to be consulted.'[67]

Hence, the meaning of 'practical' and 'appropriate' are pivotal questions which must be addressed by the doctor faced with a mentally incapacitated patient in whom CPR would be futile. Discussion is appropriate even if it offers only an illusory benefit to the patient. The benefit, it is argued, is entirely enjoyed by the relative. Both *Tracey* and *Winspear* involved recently bereaved relatives bringing their case against the defendant hospitals. In both the relatives agreed to the DNACPR orders, eventually. In both it was the relatives that derived benefit, not the subject patients. In both cases the defendant doctors were distracted from the real problems of other patients.

This seems to signal a significant shift in the object of a doctor's duty. To the patient without capacity in whom CPR will be futile it makes no practical difference whatsoever to them whether their relatives are consulted before a DNACPR decision is made. Instead, the objects of the duty are the patient's family, friends and carers. Neo-Article 8 (3) has been born.

Dyson MR and Blake J both ignored the effect of their decisions on the patient's Article 3 right; the right to freedom from inhuman or degrading treatment. Many human rights exist in equilibrium

[66] *Winspear v City Hospitals Sunderland* [2015] EWHC 3250 [50]

[67] *Winspear v City Hospitals Sunderland* [2015] EWHC 3250 [52]

with each other and more balanced judgments, as discussed below, would at least have acknowledged this.

Article 3

Article 3 of the Convention states that 'no one shall be subjected to torture or to inhuman or degrading treatment or punishment'. At first sight this seems to apply to prisoners and detainees; indeed, most cases are confined to this class of persons. However, just as Article 8 has broadened in scope, so has Article 3. The *Greek case* alluded to the right being confined to inhuman treatment which had a purpose (such as obtaining information)[68] but in *Ireland* this broadened to encompass inhuman treatment that was not deliberate.[69] Degrading treatment could be framed as 'grossly humiliating'.[70] Clearly, it would be very hard to argue that futile CPR amounts to torture but it takes little imagination to regard it as inhuman or degrading; for both recipient and possibly any unwilling participant. Two other cases illustrate the point:

In *Pretty* '[w]here treatment humiliates or debases an individual showing a lack of respect for … his or her human dignity … it may be characterised as degrading and also fall within the prohibition of Article 3' [71] and in *Soering* 'for a punishment or treatment associated with it to be "inhuman" or "degrading", the suffering or humiliation involved must in any event go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment'.[72] Both *Pretty* and *Soering* can be applied to CPR being delivered to a patient who cannot be resuscitated by such means; the effect of the CPR being to impose unnecessary suffering in the still semi-conscious or, alternatively, inhuman or degrading treatment of an unconscious patient in the last moments of life.

Lord Dyson, and by extension Blake J, were warned that their judgments might mean that health care professionals would perform CPR on dying patients in the full knowledge that the CPR would not work, simply to avoid being accused of infringing their Article 8 rights.[73]

[68] *The Greek Case* (1969) ECHR 501

[69] *Ireland v UK* (1978) ECHR 1

[70] *The Greek Case* (1969) ECHR 501

[71] *Pretty v UK* (2002) ECHR 427 [52]

[72] *Soering v UK* (1989) 11 EHRR 439 [100]

[73] *R (Tracey) v Cambridge University Hospital NHS FT* [2014] EWCA Civ 822 [92]

In the final section we will see how *Tracey* and *Winspear* have been synthesised into clinical guidance which has had the effect of championing somebody else's neo-Article 8 rights at the expense of the patient's Article 3 rights.

Response to *Tracey* and *Winspear*

With regards futility, both *Tracey* and *Winspear* commented on the 'joint statement' from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.[74] The key passage is:

> When a clinical decision is made that CPR should not be attempted, because it will not be successful, and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate the discussion with the patient to explore their wishes.[75]

In *Winspear*, Blake J did 'not consider that this [was] compatible with the Tracey case' since it did not give full effect to the patient's Article 8 rights.[76] Accordingly, the joint statement has been revised thus:

> All reasonable effort must be made to contact those close to the patient to explain the decision, preferably in person, as soon as is practicable and appropriate.[77]

Futhermore:

> Achieving a shared understanding of the patient's clinical condition and goals of care should be the aim of the conversation rather than simply to inform of a DNACPR decision. This is a complex conversation and it will rarely be appropriate to have this by telephone.[78]

This suggests that a telephone call at 3am may be practicable but inappropriate, extending the burden on the doctor (and patient) even further than Blake J suggested.[79] The 2016 joint statement goes on to warn doctors that they may be subject to civil claims of causing psychiatric harm if their conversation with relatives and carers is not sufficiently sensitive.[80]

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[74] Joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 'Decisions Relating to Cardiopulmonary Resuscitation' published in 2007.

[75] Paragraph 6.1 from the 2007 'Joint statement'.

[76] *Winspear v City Hospitals Sunderland* [2015] EWHC 3250 [55]

[77] Joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 'Decisions Relating to Cardiopulmonary Resuscitation' 3rd edition (1st revision) 2016 Paragraph 5.3

[78] Paragraph 5.3 from the 2016 'Joint statement'.

[79] *Winspear v City Hospitals Sunderland* [2015] EWHC 3250 [50]

[80] 'Evidence of any physical and/or psychological infirmity of those close to the patient, which may indicate that they are at potential risk of physical or psychological harm if they are informed of a DNACPR decision at a particular time or in a particular way. To mitigate this risk of harm, clinicians should seek to inform those close to a patient in an

The reality, post *Tracey* and *Winspear*, and in the light of recent professional guidance, is that clinicians instinctively take the line of least resistance. Since speaking briefly with relatives and carers runs the risk of causing them actionable psychiatric harm, DNACPR decisions may not be made at all. If the patient arrests then they will get CPR even if the entire team know it will be futile. Jo Samanta's naïve impression that the healthcare team would not deliver CPR if they felt it was futile[81] assumes that doctors and nurses always put their patient's interests above their own; they don't. Realistically, there are no legal consequences of performing CPR on patients without DNACPR notices. The worst outcome is a bad night's sleep knowing that a dying person's death was made uglier than it needed to be. Conversely, avoiding CPR, even where futile, requires increasingly complicated hurdles to be cleared to avoid adverse contractual, professional or legal sequelae.

Conclusion

CPR is a traumatic intervention which is frequently effective in significantly extending the life of those who would otherwise die. Where doubt exists as to its utility in an unanticipated cardiac arrest, professionals must give the recipient the benefit of the doubt and commence CPR. Where cardiac arrest is anticipated, consideration must be given to best interests. Best interest discussions mandate discussion with the patient, unless they lack capacity. Without capacity the patient's family and friends should be consulted to help elucidate the patient's best interests. The law has been very effective in championing the expression of autonomy in this respect. However, recent cases involving DNACPR notices have elided anachronistic paternalism with genuine human compassion and unwittingly threatened the dying patient's Article 3 rights. In the setting of futility there is no place for time consuming and pointless discussion with third parties if this may harm patients.

Without Article 3 to counterbalance Article 8 the fate of those dying in hospital has been passed from the hands of the compassionate to those of the cynics. Perhaps Munby's sentence in *Burke* should have been paraphrased in the dicta of *Tracey* and *Winspear*:

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optimum environment, taking into account timing, method of communication and support networks available to people close to the patient.' Paragraph 5.3 from the 2016 'Joint statement'.

[81] Jo Samanta 'Tracey and respect for autonomy: will the promise be delivered?' (2015) 23 *Med Law Rev* 467 [476]

Article 8 does not entitle anyone to commence or continue cardiopulmonary resuscitation where to do so would expose the patient to 'inhuman or degrading treatment' breaching Article 3.[82]

[82] *R (Burke) v General Medical Council* [2004] EWHC 1879 (Admin) , [2005] QB 424 [162] (*paraphrased*)

Bibliography

Statute

Offences Against the Person Act 1861

Mental Capacity Act 2005

Cases

Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67

Airedale NHS Trust v Bland [1993] UKHL 17, [1993] AC 789

Attorney-General ref no 6 1980 [1981] QB 715

Collins v Wilcock [1984] 3 All ER 374

R (Tracey) v Cambridge University Hospital NHS FT [2014] EWCA Civ 822

R (Burke) v General Medical Council [2005] EWCA Civ 1003, [2006] QB 273

R (Burke) v General Medical Council [2004] EWHC 1879 (Admin), [2005] QB 424

R (Daly) v Secretary of State for the Home Department [2001] UKHL 26

Savage v South Essex NHS Trust [2008] UKHL 74, [2009] 1 AC 681

Winspear v City Hospitals Sunderland [2015] EWHC 3250

European Law

Airey v Ireland (1979) 2 EHRR 305

Glass v United Kingdom [2004] 1 FLR 1019

The Greek Case (1969) ECHR 501

Handyside v UK (1976) EHRR 737

Ireland v UK (1978) ECHR 1

Nicklinson and Lamb v UK (2015) ECHR 23

Osman v UK (1998) ECHR 101

Peck v UK (2003) ECHR 44

Pretty v UK (2002) ECHR 427

Soering v UK (1989) 11 EHRR 439

Tyrer v UK (1978) 2 EHRR 1

Journals

Legal

Jo Samanta 'Tracey and respect for autonomy: will the promise be delivered?' (2015) 23 *Med Law Rev* 467

Loveday Hodson 'A Marriage by Any Other Name? Schalk and Kopf v Austria' (2011) 11 (1) *Human Rights Law Review* 170

M Nair-Collins 'Laying Futility to Rest' (2015) 40 *Journal of Medicine and Philosophy* 554

Medical

LJ Schneiderman, NS Jecker, AR Jonsen 'Medical futility: Its meaning and ethical implications' (1990) 112 *Annals of Internal Medicine* 949

DJ Wilkinson, J Savulescu 'Knowing when to stop: Futility in the intensive care unit' (2011) 24 *Current Opinion in Anaesthesiology* 160

A Halevy, B A Brody 'A multi-institution collaborative policy on medical futility' (1996) 276 *Journal of the American Medical Association* 571

Eduard Kralj, Matej Podbregar, Natasa Kejzarc, Joze Balazic 'Frequency and number of resuscitation related rib and sternum fractures are higher than generally considered' (2015) 93 *Resuscitation* 136

Kouwenhoven WB, Jude JR, Knickerbocker GG, 'Closed chest cardiac massage' (1960) 173 *Journal of the American Medical Association* 1064

Boehm R, 'Ueber wiederbelebung nach vergiftungen und asphyxie' (1878) 8 *Archives of Experimental Pathology and* Pharmacology 68

Daniel K Sokol '"First do no harm" revisited' [2013] BMJ <www.bmj.com/content/347/bmj.f6426> accessed 2nd March 2017

Perkins GD, Brace-McDonnell SJ, 'The UK Out of Hospital Cardiac Arrest Outcome (OHCAO) project' (2015) British Medical Journal < http://bmjopen.bmj.com/content/5/10/e008736> accessed 2nd March 2017

J Oram, P Murphy 'Diagnosing death' (2011) 11(1) *Continuing Education in Anaesthesia, Critical Care & Pain* 77

Websites

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee website < www.transfusionguidelines.org/transfusion-handbook/12-management-of-patients-who-do-not-accept-transfusion/12-2-jehovah-s-witnesses-and-blood-transfusion> accessed 9th March 2017

Resuscitation Council (UK) 'The legal status of those who attempt resuscitation '2015 <www.resus.org.uk/cpr/legal-status-of-those-attempting-cpr/> accessed 2nd March 2017

Key Statistics from the National Cardiac Arrest Audit 2015/16 < www.resus.org.uk/research/national-cardiac-arrest-audit/> accessed 2nd March 2017