Covid-19-legal issues – a response to the BMA

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On April 1st 2020, in response to the increasing demands on the NHS posed by the Covid-19 pandemic, the British Medical Association (BMA) published a document entitled 'COVID-19 – ethical issues. A guidance note'.

On page 3 of the document:

> Health professionals may be obliged to withdraw treatment from some patients to enable treatment of other patients with a higher survival probability. This may involve *withdrawing treatment from an individual who is stable or even improving* but whose objective assessment indicates a worse prognosis than another patient who requires the same resource. (*emphasis added*)

A similar approach was endorsed by Truog very recently, also on utilitarian grounds.[1] Cited in support of the BMA position was *R (BA) v The Secretary of State for Health and Social Care*.[2] This case questioned the discretion of the Secretary of State for Health to prioritise the allocation of organs for transplantation based on the ordinary residence of the potential recipient. The Court of Appeal ruled that the secretary of state was empowered (by virtue of S.3(1) National Health Service Act 1977 and s.8 and s.272 of the subsequent 2006 Act) to issue directions to that effect. In essence, scarce resources can be allocated to defined classes of persons, delineated along reasonable criteria.[3] It is easy to substitute ventilators or intensive care beds into the case and reach the same conclusion. Furthermore, in *R v Cambridge DHA Ex parte B (No.1*) *Sir Thomas Bingham* acknowledged that:

> [i]t 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

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[1] RD Truog 'The Toughest Triage — Allocating Ventilators in a Pandemic' New England Journal of Medicine March 23, 2020 page 2

[2] *R (BA) v The Secretary of State for Health and Social Care* [2018] EWCA Civ 2696

[3] "In exercising his judgment, the Secretary of State is entitled to take into account the resources available to him and the demands on those resources. In *R v Secretary of State for Social Services, Ex p Hincks (1980) 1 BMLR 93* the Court of Appeal held that section 3(1) of the 1977 Act does not impose an absolute duty to provide the specified services. The Secretary of State is entitled to have regard to the resources made available to him under current government economic policy." *R (BA) v The Secretary of State for Health and Social Care* [2018] EWCA Civ 2696 [63]

> budget is best allocated to the maximum advantage of the maximum number of patients.[4]

Additionally, *N (Appellant) v ACCG and others* [2017] UKSC 22 established that a person's 'best interests', as defined by the Mental Capacity Act 2005, cannot successfully consume resources that would be ordinarily limited or unavailable for a patient with capacity. In applying this to the rationing of resources during a pandemic, the incapacitated cannot access intensive care resources simply by virtue of their 'best interests' not being met if denied them.

However, in spite of this legal authority, there are other legal issues which cannot be ignored before doctors can lawfully remove a resource from an improving patient (on which they are mortally dependent) in order to give the resource to another. Utilitarian ethics are one thing (and the authors make no attempt to argue against these principles) but assuming one particular ethical doctrine directly correlates with current English law to the exclusion of all other ethical principles could be a mistake.

The scope of judicial review

Judicial review allows a judge to examine the lawfulness of decisions made by public bodies. Grounds for judicial review include illegality, impropriety, irrationality and proportionality.[5] A judicial review can make binding comment on the lawfulness of the process employed by the court or tribunal in making a given decision but it is not a mechanism to make lawful that which is unlawful. The authors readily concede that limited resources require an appropriate authority to decide on how public resources are deployed and that a court of law, whilst having the jurisdiction to do this, is not necessarily the expert authority best placed to intervene in matters of resource allocation. As concluded by Sir Stephen Brown P in *Cambridge*: 'The powers of this court [Court of Appeal (Civil Division)] are not such as to enable it to substitute its own decision in a matter of this kind for that of the authority which is legally charged with making the decision'.[6] The authors are suggesting that the activity outlined by the BMA is unlawful, beyond the scope of judicial review and requires parliamentary approval before deployment 'in the field'. It is necessary that we now justify our position.

[4] *R v Cambridge DHA Ex parte B (No.1*) [1995] 1 WLR 898 [906]. This case received widespread media attention and concerned the denial of funding for the treatment of a ten-year old girl suffering from myeloid leukaemia. The treatment was expensive and considered to have little prospect of success.

[5] *Council of Civil Service Unions v Minister for the Civil Service* [1984] UKHL 9

[6] *R v Cambridge DHA Ex parte B (No.1)* [1995] 1 WLR 898

Removing a vital resource from an individual requires a lawful basis: Withdrawing and withholding

It is not our intention to get into a lengthy philosophical discourse, however, it would be reasonable to say that the purpose of a treatment is to alter the natural course of a harmful event or process to the benefit of the person afflicted. Sometimes doctors are successful, other times they are not, and lying between these two end-points there is a whole spectrum between complete success and abject failure. From the perspective of the patient, it may be beneficial to continue a treatment even if the intended outcome is not what was desired. What is viewed by one patient as a relative success could be seen as a failure by another. Withdrawing a failing treatment can result in the patient dying earlier than they would have done had the treatment been continued. Is the act of withdrawing life-sustaining treatment the same as causing death or is it simply withholding a treatment that serves no benefit?

In *Airedale NHS Trust v Bland*,[7] Tony Bland had suffered severe hypoxic brain injury during the Hillsborough tragedy in 1989 leaving him in a permanent vegetative state (PVS). Medical expert opinion was agreed that he had no prospect of recovery and the court deemed that withdrawing life sustaining support was no different, in law, from withholding it. Tony Bland's best interests were not being served by keeping him continuously artificially nourished and hydrated (CANH). Consequently, removing CANH was merely omitting a non-beneficial treatment.

It is commonplace for patients who have embarked on a course of intensive care treatment, who do not respond favourably, to have that treatment withdrawn.[8] The General Medical Council discourage the use of ineffective treatments not least because of the waste of resources.[9] The consent of the patient (for those with the capacity to decide) or best interests (for those lacking capacity) are central to clinical decisions regarding whether a given treatment should start, continue or be withdrawn.[10] The result of withdrawal from a ventilator is usually the death of the patient but this is in the context of not improving. The BMA suggest that it would be lawful to withdraw therapy on a patient who is improving; based on the fact

[7] *Airedale NHS Trust v Bland* [1993] AC 789

[8] Over 40% of all patients who die on UK intensive care units do so following withdrawal of treatment. <www.icnarc.org/Our-Audit/Audits/Cmp/Reports/Summary-Statistics>

[9] General Medical Council 'Good Medical Practice' April 2014 < www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice> accessed 7th April 2020

[10] Consent is defined by the General Medical Council document '*Consent: patients and doctors making decisions together'* (2008) and best interests are defined in S.4 Mental Capacity Act 2005. The Mental Capacity Act 2005 provides the lawful authority for treatment of patients lacking capacity. In relation to the withdrawal of life sustaining treatment the best interests test was elaborated by Lady Hale in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67

that rationing is lawful and best interests cannot be used to gain a resource which rationing would ordinarily deny them.

There are fundamental differences between taking an improving patient off a ventilator (on which they are dependent and thus allowing them to die within a few minutes), and refusing to embark on a treatment because the potential recipient lies outside that group lawfully eligible for that resource.

First, the ventilator dependent patient was deemed within the eligible group to receive ventilator support. In other words, the patient either consented to the treatment or if the patient lacked capacity to consent, ventilation was considered to be in their best interests. Applying a more limited inclusion group *post hoc* is analogous to applying laws retrospectively. There are sound ethical grounds for not doing this which touch on fundamental human rights.[11] As described in a recent blog by Thomas from Serjeants' Inn Chambers:

> '[T]he BMA discussion is solely about the refusal to provide treatment in the first place, not removal of treatment from a person already being treated. To focus on the analogy provided [organ donation], ventilator withdrawal is akin to embarking on a heart transplant operation and then deciding part way through to give the donor heart to another patient.'[12]

Second, the state has an obligation to protect the right to life (Article 2 of the European Convention on Human Rights); this is an absolute right.[13] Whilst the intention of the doctor would be to make the ventilator available for another (rather than to kill the patient) the association between the intention and the inevitable result cannot be ignored. This may fall squarely in the criminal arena as a potential murder.[14] Against this sobering thought the 'double effect' principle has enabled doctors to give compassionate care to those at the end of their lives since Lord Devlin's judgement in *Bodkin-Adams* from the 1950's.[15] Here, the administration of opiate analgesia to control pain was associated with hastening death. The principle requires that the intention is not to kill but accepts that death may be hastened. The 'double effect' principle only applies to individual patients. If patient A dies as a side effect of a properly indicated treatment whose primary purpose was to give remedy, then the doctor

[11] Article 7 of the European Convention on Human Rights

[12] <ukmedicaldecisionlawblog.co.uk/rss-feed/119-covid-19-allocation-and-withdrawal-of-ventilation-the-urgent-need-for-a-national-policy> accessed 10th April 2020

[13] "No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law." It is not possible to derogate from Article 2

[14] 'Where a man realises that for all practical purposes it is inevitable that his actions will result in death or serious harm, the inference may be irresistible that he intended that result, however little he may have desired or wished it to happen.' *R v Nedrick* [1986] 1 WLR 1025 [1028] Lord Lane

[15] *R v Adams* [1957] Crim LR 365

has not acted unlawfully.[16] This principle, however, does not extend to taking treatment from A to give to B.

Third, the UK mortality for ventilated patients with Covid-19 disease is currently around 50%.[17] A civil court accepts a standard of proof based on the balance of probabilities.[18] If a patient, refused a ventilator, were to die (through an omission to take that ventilator from another) there could be a cause of action in negligence. In *Gregg v Scott*, the defendant's negligence reduced the claimant's chance of recovery from 42%-25%.[19] Even if the defendant had done as he should, the patient would, on the balance of probabilities, still not have recovered. The reduction in recovery prospects (loss of chance) was judged insufficient to attract damages; the claimant needed to show he had been moved from likely to recover to unlikely to recover in order to make a successful claim. Hence, even if the chance of recovery were taken away from the patient already ventilated the fact they were more likely than not to die anyway means that there would be no prospect of a legal remedy in a civil court. On the other hand, the patient requiring the ventilator, their chances of survival with it would be better than the patient already on it. For them there would be a 'loss of chance' if denied ventilation that would move their prospects from likely to survive, to unlikely to survive. The 'loss of chance' has shifted the odds of survival across the more likely than not threshold. If the doctor has been in breach of professional standards by NOT removing the ventilator from the first patient then damages could be readily recovered by the patient denied it.

Fourth, a doctor has 'a fundamental … duty of care … to take such steps as are reasonable to keep the patient alive.'[20] Additionally:

> No authority lends the slightest countenance to the suggestion that the duty on the doctors to take reasonable steps to keep the patient alive in such circumstances may not persist. Indeed, it seems to us that for a doctor deliberately to interrupt life-prolonging treatment in the face of a competent patient's expressed wish to be kept alive, with the intention of thereby terminating the patient's life, would leave the doctor with no answer to a charge of murder. [21]

[16] In law, a person's death is regarded as having been caused if it has been hastened by the criminal or negligent act of another. The hastening act need not be the principal cause of death. That it *"more than minimally negligibly or trivially contributed"* will suffice. *R v HM Coroner for Inner London ex parte Douglas-Williams* [1998] EWCA Civ 101, [1999] 1 All ER 344

[17] ICNARC report on COVID-19 in critical care 04 April 2020 <www.icnarc.org/About/Latest-News/2020/04/04/Report-On-2249-Patients-Critically-Ill-With-Covid-19> accessed 6th April 2020

[18] In other words, a position that is more likely than not. A criminal court requires a much higher standard of proof – beyond reasonable doubt.

[19] *Gregg v Scott* [2005] UKHL 2

[20] *R (Burke) v General Medical Council* [2005] EWCA Civ 1003 [2006] QB 273 [32]

[21] *R (Burke) v General Medical Council* [2005] EWCA Civ 1003 [2006] QB 273 [34]

Murder, a common-law offence, can be defined as the 'killing of another human being, under the 'Queens Peace', with malice aforethought'.[22] The archaic term 'malice aforethought' has been clarified as meaning intentional.[23] This could be applied to intentionally killing someone who wants to die; assisted suicide. However, the law recognises that assisting a suicide does not carry with it the same sense of public outrage as intentional killing someone who does not want to die. Murder carries with it a life sentence[24], assisting a suicide can result in 14 years imprisonment.[25]

As we have highlighted, an act which causes death can be lawfully justified either by the 'double effect' principle (*Adams*) or withdrawing therapy based on best interests (*Bland*). Withdrawing therapy in the full knowledge that this will cause death against the best interests or consent of the individual falls into neither group. To allow doctors to act in this way requires either new law or the issue of novel instructions to prosecutors. The latter approach is not unprecedented.

The CPS was established under the Prosecution of Offences Act 1985 as an independent judicial agency responsible for the preparation and presentation of criminal prosecutions in the UK. This followed a series of reports in the late 1970s and early 1980s recommending that the functions of investigating crime and prosecuting crime be kept separate. They have a two-stage test before recommending a prosecution.[26] First is the evidential stage where the prosecutor assesses the evidence and decides whether it is sufficiently strong to secure a conviction. Then there is a public interest stage questioning whether there is sufficient public interest in a prosecution. For assisted suicide cases, the CPS have special rules which appear to reduce the chances of a person being prosecuted for assisting suicide.[27] Arguably, this mechanism of protecting doctors from prosecution would allow the BMA guidance to be followed. We are unaware of any such directions to the CPS relating to the current Covid-19 pandemic.

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[22] *R v Woollin* [1999] 1 Cr App R; *R v Matthews (Darren John)* [2003] EWCA Crim 192

[23] *R v Maloney* [1985] 1 All ER 1025; *Hyam v DPP* [1975] AC 55

[24] Government website <www.gov.uk/types-of-prison-sentence/life-sentences> accessed 12th April 2020

[25] S.2 (1c) Suicide Act 1961

[26] Crown Prosecution Service <www.cps.gov.uk/publication/code-crown-prosecutors> accessed 10th April 2020

[27] Cases of encouraging or assisting suicide are dealt with in Special Crime Division in CPS Headquarters. The Head of that Division reports directly to the DPP. Any prosecutor outside Special Crime Division of Headquarters who receives any enquiry or case involving an allegation of encouraging or assisting suicide should ensure that the Head of Special Crime Division is notified. <www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide> accessed 10th April 2020. Also S.2(4) Suicide Act 1961 'no proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions.'

Current English criminal law appears to favour a murder conviction for withdrawing ventilation from patients against their best interests. Not withdrawing ventilation would appear to give the patient denied the ventilator a case in negligence. What defence could the doctor mount in either court?

Potential defences for the doctor in a criminal court

Necessity

In Re:A,[28] conjoined twins, Jodie and Mary were joined at the pelvis and the medical opinion was that both would die if they were not surgically separated.[29] The medical opinion was also that following separation, one of the twins, Mary would die. Once separated, it was considered that Jodie would survive much longer than if still conjoined. The doctors sought legal advice as to whether 'necessity' would act as a defence should they be arrested and charged with murder by carrying out the operation.[30] The case was heard in the Court of Appeal who, after much deliberation, opined that 'necessity' would probably form a complete defence if the case were to reach the criminal courts.[31] The operation proceeded and the outcome was as predicted; Mary died and Jodie lived. No criminal case was brought on which to test the defence of necessity. The leading criminal case exploring necessity as a defence to murder is still the grisly case of *R v Dudley and Stephens*[32] and that court (the House of Lords) ruled that it was *not* a satisfactory defence. Here, the shipwrecked and starving defendants cannibalised a dying cabin boy in order to stay alive.

Necessity has been relied on in UK intensive care units to justify minor harm for decades. Utilitarian principles have determined that where one hospital's capacity for intensive care patients is to be exceeded, the patient likely to suffer the least by being transferred to a less busy intensive care is the one selected for transfer. These non-clinical transfers occur

[28] *Re: A (Children)* [2001] 2 WLR 480, [2001] Fam 147;

[29] For a summary see D Tausz 'Surgical separation - whether surgical separation of conjoined twins that would lead to death of non-viable twin lawful' [2001] Criminal Law Review 400

[30] For the purposes of criminal law this is "An act which would otherwise be a crime may in some cases be excused if the person accused can show that it was done only in order to avoid consequences which could not otherwise be avoided, and which, if they had followed, would have inflicted upon him or upon others whom he was bound to protect inevitable and irreparable evil, that no more was done than was reasonably necessary for that purpose, and that the evil inflicted by it was not disproportionate to the evil avoided" Sir James Stephen(1887) Digest of the Criminal Law (4th edition). Approved in *Re: A (Children)* [2001] 2 WLR 480, [2001] Fam. 147 [240]

[31] For further exploration and criticism of the ethical issues raised in *Re:A* see Richard Huxtable 'Separation of conjoined twins: where next for English law? [2002] Criminal Law Review 459 and Simon Gardner 'Direct action and the defence of necessity' [2005] Criminal Law Review 371

[32] *R v Dudley and Stephens* (1885) LR 14 QB 273

hundreds of times per year.[33] It is seldom in the transferred patient's best interests to be moved. It can result in modest physiological deterioration and it often means greater separation from relatives but harming one patient to avoid greater harm in another is not unusual. This, however, does not extend to causing death in one patient to avoid death in another.

Duress

Duress has long been recognised as a defence to a criminal act. 'Duress of threats' applies if the actor reasonably believes that they will suffer death or serious injury by not committing the crime.[34] Here the threat is directly from another person. 'Duress of circumstance' applies if the actor believes that they will suffer death or serious injury by virtue of the circumstances they are in. For instance, breaking speed limits in order to avoid being harmed.[35] The threat need not be to the individual themselves, it could be directed toward someone they know or possibly even a complete stranger.[36]

In the medical field, duress is an unlikely scenario although threats from relatives cannot be discounted as possible. Medical authorities could conceivably pressure clinicians into breaking the law by threatening a professional's status or livelihood although this falls a long way short of serious harm or death.

Potential defences for the doctor in a civil court

Standard of care

In order to be found negligent, a doctor must cause harm to his patient by a breach of duty of care. Provided the act or omission of the doctor accords with those of their peers, there is no breach of duty[37] unless the act or omission was illogical.[38] The Bolam principle, with the illogicality caveat expressed in *Bolitho*, allows the evolution of standards of care against which the defendant doctor will be judged. Hence, withdrawing a patient from a ventilator against their best interests could be an acceptable standard in times of crisis. For the NHS doctor, the security of Crown indemnity would mean their NHS employer would be liable for damages, not the doctor themselves.

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[33] Intensive Care National Audit and Research Centre (ICNARC) <onlinereports.icnarc.org/Reports/2019/12/annual-quality-report-201819-for-adult-critical-care#> accessed 9th April 2020

[34] *R v Howe* [1987] 1 AC 417 HL

[35] *R v Hasan* [2005] UKHL 22

[36] *R v Shayler* [2002] UKHL 11

[37] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582

[38] *Bolitho v. City and Hackney Health Authority* [1996] 4 All ER 771

Conclusion

In the event of resource limitation there needs to be a coherent and lawful way to distribute those resources. The courts, by way of judicial review, have given health authorities considerable latitude to determine the allocation of resources provided the process of decision making is neither illegal, irrational, illogical or disproportionate. Predictive tools are available to clinically determine which patients are most likely to benefit from any given resource; in the present Covid-19 pandemic these resources include ventilators and intensive care support. Applying such utilitarian principles is not new to the NHS which has always had to do the best it can with whatever resources it is given. Once a patient has begun a course of treatment, based on clinically predictive tools and lawfully determined inclusion criteria, it would be unusual to then withdraw that treatment because new inclusion criteria had been developed; even more unusual if that person were to die as a result.

The BMA's proposal may have ethical merit but it lacks adequate legal support. Only parliament or the Supreme Court possess the power to radically alter the law; healthcare authorities can merely advise on what might happen if their own advice is followed. This is an unsatisfactory position to leave doctors in.