



# Medical Update

---

October 2012

## Legislation focus

### Withdrawal of life-saving treatment – “Do Not Resuscitate” orders

Do Not Resuscitate orders (DNRs) have recently become the subject of much debate [more>](#)

## Recent cases and other news

Complaints about doctors hit record levels [more>](#)

### Unauthorised access to medical records

*Grinyer v Plymouth Hospitals NHS Trust [2011]* [more>](#)

Clarification on 10% general damages increase [more>](#)

Any comments or queries

### Clare Jaycock

#### Head of Risk

[clare.jaycock@rpc.co.uk](mailto:clare.jaycock@rpc.co.uk)

D +44 (0)20 3060 6425

### Rowan Brown

#### Senior Associate

[rowan.brown@rpc.co.uk](mailto:rowan.brown@rpc.co.uk)

D +44 (0)20 3060 6473

### Richard Manstoff

#### Associate

[richard.manstoff@rpc.co.uk](mailto:richard.manstoff@rpc.co.uk)

D +44 (0)20 3060 6326

## Legislation focus

### Withdrawal of life-saving treatment – “Do Not Resuscitate” orders

#### The current debate

Do Not Resuscitate orders (DNRs) have recently become the subject of much debate. This follows media exposure of a case in which an NHS Trust in East Kent issued a patient with Down’s syndrome (identified only as AWA) with a DNR order, without his or his family’s consent. His family are now suing the Trust.

AWA had dementia and was fed by a tube through his stomach. In his DNR order, disability was cited as the sole reason for the imposition of the order. Members of AWA’s family had been at the hospital on a daily basis and there were numerous opportunities for them to have been consulted on the decision to withhold treatment.

The case highlights either a serious miscommunication error or, perhaps, a deliberate decision taken by doctors based on their assessment of AWA’s quality of life.

In this article we look at the consequences of this decision and the wider implications. The article will also question whether there is the need for a nationwide policy for DNR orders rather than leaving it to individual NHS Trusts.

#### Two key aspects: communication and consent

DNRs or DNACPR (“do not attempt cardiopulmonary resuscitation”) are written instructions to withhold CPR in the event of a cardiac or respiratory arrest.

CPR is a highly invasive intervention. It involves chest compressions, defibrillation, artificial ventilation and can involve the injection of drugs to restart the heart. For patients who have experienced a stroke, a severe injury/infection, cancer, or liver failure, resuscitation will very often fail, and there is no way of knowing, in advance, what condition a patient will be left in – even if they are successfully resuscitated. In the case of a serious stroke for example, there is a risk that a resuscitated patient will be left in a permanent state of either partial or full paralysis. There are many who would not wish to live in those circumstances, particularly if they are elderly, and/or have a terminal condition which would otherwise end their life in the near future. They would instead prefer, following a significant cardiac arrest or respiratory failure, that they simply “...do not wake up”. Some make that choice in advance and communicate it to their treating doctors so that all are aware of the position.

Underpinning any decision on CPR, it remains the case that doctors cannot be expected to (and are not legally obliged to) provide a treatment or intervention which they do not believe is going to work, or which is not in the patient’s best interests.

This was illustrated very recently in a case where the family of a severely brain-damaged Muslim patient wanted every possible intervention to be undertaken with a view to prolonging his life. His doctors had decided that, if his condition worsened, it would not be in his best interests to attempt resuscitation. The family said that not to do so was against their Muslim faith. The court found in favour of the doctors, who were permitted to withhold life sustaining treatment on the basis that this would not prolong the patient's life "in any meaningful way".

### Guidelines

The British Medical Association/Royal College of Nursing and the General Medical Council have issued guidelines on the issue. They are as follows:

- BMA, Resuscitation Council (UK) and RCN – "Decisions relating to Cardiopulmonary Resuscitation"
- GMC – "Treatment and care towards the end of life: good practice in decision making"

The guidelines identify three situations in which withholding CPR may be legally and ethically justifiable.

1. The patient has made an advance decision (living will);
2. Clinical judgement concludes that CPR will not be successful in restoring the patient's heart, breathing and circulation – for example, if a patient is dying from another irreversible condition;
3. When, following careful discussion with the patient and/or those close to him, there is an agreement that the benefits of CPR are outweighed by the burdens and risks.

The guidelines emphasise the importance of communication, which appears to have been so lacking in this case. If a patient does not wish to discuss the issue, it should be raised with the family in appropriate circumstances, though with the proper constraints of patient confidentiality and the patient's express wishes in mind. It is important to remember that only the patient, if they have capacity, can request or mandate a DNR order, or make an advance decision refusing future treatment.

In circumstances where the clinical view is that CPR or other intervention would be futile or would not be in the patient's best interests, doctors may, unilaterally, decide to withhold treatment. However, that should, if at all possible, be discussed with the patient and/or their relatives and there can be very few situations in which that clinical decision should be taken in private, and kept from the patient and/or their family.

The vast majority of DNR orders are agreed with patients, or are implemented at their request. Although most, if not all, trusts will have a written policy or guidance in place, the implementation of a nationwide policy would create a recognised framework which would, arguably, encourage the openness and transparency that this issue requires and deserves.

It would also provide a measure of protection to the clinical staff provided that its requirements had been followed. This is also important as it must be remembered that the placing of a DNR order on a patient's file without proper consideration, care or clinical judgement, is unlawful. Any such act is punishable both by the GMC (in the case of a doctor) as regulator, and possibly by the courts, in criminal law. It follows also that civil liability may attach.

**Law/ethics/medicine**

This issue is one which requires, in each case, very careful consideration of the individual patient's clinical condition, the wishes of the patient or their relatives, and the law and principles of both legal and medical ethics. Decisions often have to be made in fast moving and highly charged situations where there may not be the luxury of time. It is for exactly that reason that these issues should be considered in advance, and discussed openly with the people involved, wherever possible. [back to contents](#)>

## Recent cases and other news

### Complaints about doctors hit record levels

The General Medical Council received 8,781 complaints in 2011, an increase of 23% from 2010. A total of 3,465 investigations were completed by the GMC, resulting in 65 doctors being erased from the register. The most common allegations included substandard treatment, financial deception, false and misleading reporting, incomplete medical records, failure to cooperate with an investigation, and fraud.

One doctor in 64 was investigated in 2011, compared with one in 68 in 2010. Over a working career, this means that every doctor has a significant chance of being investigated by the GMC.

NHS complaints about doctors far exceeded those for other staff groups. Male doctors and those who qualified over 20 years ago were represented disproportionately, as were those in general practice, psychiatry and surgery.

More details can be found here: [http://www.gmc-uk.org/The\\_state\\_of\\_medical\\_education\\_and\\_practice\\_in\\_the\\_UK\\_2012\\_0912.pdf\\_49843330.pdf](http://www.gmc-uk.org/The_state_of_medical_education_and_practice_in_the_UK_2012_0912.pdf_49843330.pdf)

[back to contents>](#)

### Unauthorised access to medical records

In *Grinyer v Plymouth Hospitals NHS Trust* [2011] the court considered the effects of an employee's unauthorised access to medical records, and suitable damages under the Data Protection Act.

The claimant had a paranoid personality disorder and was involved in a relationship with a nurse (P) at the hospital. During the course of their relationship, the claimant was aware that P had accessed personal medical records, but took no action. Eight months later, after the relationship had ended, P visited the claimant's children at his father's house. It was apparent to the claimant that P had either accessed personal records again, or that more information had been obtained than previously realised – as the father's address could only have been obtained from medical records.

The claimant made a complaint to the defendant trust (T), explaining that so much stress had resulted from the incident that he had suffered an exacerbation of symptoms and had been unable to take up a new job.

The claimant brought a claim against T for damages under the Data Protection Act. The claim was for the effect on the claimant's health, employment losses, treatment costs and aggravated damages – as a result of T's handling of his complaint. T argued that an award under the Data Protection Act was not possible.

The court found in favour of the claimant and damages were awarded. Although the facts were unusual, the court found that the Data Protection Act did allow the claimant to recover for personal injuries and, given the claimant's pre-existing condition, exacerbation of his condition was foreseeable as a result of the breaches of the Act. Damages were reduced to reflect that the claimant would have struggled with his mental health in any event and the court did not allow aggravated damages.

The case illustrates that in certain circumstances, damages can be recovered for personal injury for breach of the Data Protection Act. [back to contents>](#)

### Clarification on 10% general damages increase

Following an application by the Association of British Insurers, the Court of Appeal has revised the guidance given in *Simmons v Castle* [2012] EWCA Civ 1039 on the proposed 10% increase in general damages. The increase will not be awarded to claimants who have entered into a CFA before 1 April 2013. Other than this exception, the increase will apply to all general damages awards after 1 April 2013, regardless of when the claim was commenced. [back to contents>](#)

ID ref: 12330