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Medical decision making when demand for respiratory services exceeds NHS capacity

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The nature of the problem.

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- How does the NHS take decisions about who gets access to critical care if the number of patients who need critical care support exceeds the NHS's capacity to provide that support;
- Can the NHS lawfully:
  - Ration who gets access to critical care treatment
  - Withdraw treatment from those not progressing in favour of others.

- Can NHS rationing be lawful in public law terms?
- Would it be unlawful discrimination?
- Would it lead to doctors being prosecuted for manslaughter or struck off the GMC register?
- If need for critical care exceeds supply, what else should doctors do?

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Is this a problem now?

But will it be a problem in future?

- Answer is “nobody knows for sure”
- Everyone hopes enhanced critical care capacity will meet the need
- But no one knows for certain
- NHS areas are planning for all foreseeable eventualities – and this is clearly foreseeable
- So the questions need to be addressed.

BMA Guidance (1)

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"During this pandemic, it is possible that demand on health services may outstrip the ability of the NHS to deliver services to pre-pandemic standards. As we have seen in China, Italy and Spain, deaths frequently follow hospitalisation and critical care interventions. In Wuhan, 5% of those infected were admitted to ICU, and 2.5% required mechanical ventilation. It is possible therefore that restrictions in the availability of mechanical ventilation may for a period become severe.

Although not everyone will become ill at once, the initial wave of illness can be extremely rapid, over a few days to a few weeks. In these circumstances, if demand outstrips the ability to deliver to existing standards, more strictly utilitarian considerations will have to be applied, and decisions about how to meet individual need will give way to decisions about how to maximise overall benefit."

BMA Guidance (2)

“Doctors would be obliged to implement decision-making policies which mean some patients may be denied intensive forms of treatment that they would have received outside a pandemic. 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 ….

Although doctors would likely find these decisions difficult, if there is radically reduced capacity to meet all serious health needs, it is both lawful and ethical for a doctor, following appropriate prioritisation policies, to refuse someone potentially life-saving treatment where someone else has a higher priority for the available treatment”

BMA Guidance (3)

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Triage: Triage is a form of rationing or allocation of scarce resources under critical or emergency circumstances where decisions about who should receive treatment must be made immediately because more individuals have life-threatening conditions than can be treated at once ….

In these circumstances it is likely that priority will ordinarily be given to those whose conditions are the most urgent, the least complex, and who are likely to live the longest, thereby maximising overall benefit in terms of reduced mortality and morbidity. ”

BMA Guidance (4)

- To maximise benefit from admission to intensive care, it will be necessary to adopt a threshold for admission to intensive care or use of scarce intensive treatments such as mechanical ventilation or extracorporeal membrane oxygenation. Relevant factors predicting survival include severity of acute illness, presence and severity of co-morbidity and, where clinically relevant, patient age.

- Those patients whose probability of dying, or of requiring a prolonged duration of intensive support, exceeds a threshold level would not be considered for intensive treatment, though of course they should still receive other forms of medical care"

Is NHS rationing lawful?

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- Yes – according to a long series of cases
- *R v Central Birmingham Health Authority ex parte Collier* [1988 WL 1608598]
- *R v Cambridge Health Authority ex parte B* [1995] 1 WLR 898
- *R (BA) v The Secretary of State for Health and Social Care* [2018] EWCA Civ 2696 where NHS rules made by the Secretary of State in Directions prioritising donated organs for those lawfully resident in the UK were unsuccessfully challenged.

University College v MB

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- Very recent decision from Chamberlain J

- *“In some circumstances, a hospital may have to decide which of two patients, A or B, has a better claim to a bed, or a better claim to a bed in a particular unit, even ceasing to provide in-patient care to one of them to leave will certainly cause extreme distress or will give rise to significant risks to that patient's health or even life. A hospital which in those circumstances determines rationally, and in accordance with a lawful policy, that A's clinical need is greater than B's, or that A would derive greater clinical benefit from the bed than B, is not precluded by Article 3 ECHR from declining to offer in-patient care to B”*

Human Rights complaints

- Questionable whether human rights are even engaged in NHS rationing decisions: see *R (Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910 [2012] PTSR 460

- Long series of ECtHR cases where the court has refused to engage with the problems of inadequate state funded health care services: *Sentges v Netherlands*, no 27677/02, 8 July 2003; *Pentiacova v Moldova*, no 14462/03, 4 January 2005; *Tysiac v Poland* (2007) 22 BHRC 155

- Only possible grounds are article 14 discrimination – but no cases.

- Hence ECHR grounds probably do not assist.

Will doctors be exposed to negligence claims?

- How can doctors not act negligently if they make decisions which result in their patients having sub-optimal medical treatment?

- Answer is not straightforward, but in essence:

  – clinicians working in the NHS can be simultaneously make decisions as a doctor who owes a private law duty of care to a patient and as a public law decision maker who has to take decisions on the basis of rationing resources – and there cannot be different legal rules for each.

  – Hence doctors should not be able to be sued in negligence for making lawful public law decisions.

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Standard of care is affected by available resources.

- See academic text "*Who should we treat*" by Professor Chris Newdick (OUP: 2005) at page 187 in a chapter entitled "*Are negligence standards resource dependant?*" The answer to that question given by Professor Newdick is "Yes".

- *Knight v Home Office* [1990] 3 All ER 237

- *King v Sussex Ambulance Service NHS Trust* [2002] ICR 1413

- *Humphrey v Aegis Defence Services Ltd and another* [2017] 1 WLR 2937

Summary on negligence

- A public law decision maker who takes a decision based on a rational policy which allocates treatment based on a fair allocation of medical resources as between different patients should not be liable in private law negligence for failing to provide a service with resources at a greater level than afforded by the public law decision.

- Reason is that a breach of public law duties does not, of itself give rise to any liability and it cannot be reasonable to expect a doctor or other clinical professional to provide additional medical resources to a patient over and above that which the public law allocation decision has determined.

Equality considerations

- It could be indirect discrimination but it would be a proportionate means of achieving a legitimate aim, namely maximising the number of lives to be saved

- Duty to make reasonable adjustments is engaged – but what adjustments can be reasonable where (a) there is no clear evidence base and (b) the standards will constantly shift depending on the need/resources equation

- Test on proportionality explained in *R (Steinfeld and Keidan) v Secretary of State for International Development (in substitution for the Home Secretary and the Education Secretary)* [2018] UKSC 32.

Criminal and regulatory considerations

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- Patients would die from their underlying conditions, not because of withdrawal of care: see *Airedale NHS Trust v Bland* [1993] AC 789

- Cannot be in the public interest to prosecute a doctor for the consequencecs of following a lawful Trust policy to prioritise case on those who can benefit most

- No breach of the GMC Code as no case to support unfitness

So in summary

Assuming these circumstances arise, the dilemma for those in the NHS planning how to respond to the Covid-19 pandemic is thus not "*whether*" these terrible types of decisions will need to be made but:

- "*how*" these decisions should be made – i.e. by what criteria, and
- *whether* any proposed decision making system which is sufficiently clear it will be lawful.

What should NHS bodies in practice?

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- Work with their clinicians to ask and answer the difficult questions about how these decisions should be taken

- Develop draft policies and engage with the public (albeit briefly) to satisfy s14Z2 and 242 of NHS Act

- For Boards to consider and adopt policies to guide clinical decision making.

- Ensure that front line clinicians have accurate and up to date information about extent of patient need and extent of available critical care resources

What would be inexcusable?

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Thank you for listening

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