



Evening Medical Update: Medicolegal Challenges **Tuesday 23 June 2020**

Medical Law: Capacity and detentions – Dr Matthew Sheridan

CAVEAT – I practice in Scotland so the Mental Health legislation is not the same as the rest of the UK. I can't give detailed guidance on countries out with Scotland – sorry. Many of the principles of capacity assessment will be similar, but you should check with local colleagues if unsure.

Many times in AMU we get young people, who have either taken an overdose or deliberate self-harm, who want to leave hospital against medical advice – by taking an overdose or deliberate self-harm, can we take it that they do not have the mental capacity to leave hospital?

No - in Scotland – the patient needs to be assessed and consideration given to whether they require detention firstly and secondly whether they have capacity to refuse treatment. We can't assume lack of capacity by their actions.

Is it legal to use mittens for a demented patient who keeps pulling out a cannula?

In Scotland, the NWC has issued guidance on right to treat. All measures should be tried before use of force such as use of 1-1 nursing care, relatives etc. If the risk of not being treated is high and the patient lacks capacity then it may be necessary to use an approach like this temporarily. This is always the kind of decision that relatives and the full MDT take part in to ensure it is in the person's best interests and is the least restrictive.

Can you detain a patient in A&E? I have been told so far that a person can only be detained if they are an inpatient.

In Scotland – yes.

Is a psychiatric assessment recommended for a patient refusing life-saving treatment to rule out depression/suicidal ideation?

Potentially yes, depending on the reason why the patient is refusing and whether there are other signs of mental disorder. Those with chronic conditions may make a decision with full capacity to refuse treatment, in the same way that some people refuse further oncology treatment.

Can a patient be moved to a care home whilst they are under court protection?

The Court of Protection is in England and Wales, I would suggest that you check with the court.

Can a mental health approved doctor do a DOLS Assessment?

This is not legislation which is used in Scotland.

Usually a capacity assessment is done by Junior Doctors, sometimes it is difficult to assess when a patient has intermittent delirium – what is your recommendation?

Intermittent delirium relies on good history from nursing and auxiliary staff. If present then this will influence a person's capacity if they have no memory or appreciated of being more delirious. Where doubt exists after junior assessment then capacity assessment should be done by senior staff.

Do we need to do the paperwork to treat (Mental capacity assessment or Deprivation of liberties) a patient with advanced dementia on every admission?

No legislation used in Scotland. In Scotland all people who lack capacity should have a section 47 treatment form completed upon admission to hospital.



Law and ethics around decision-making at end of life – Dr Stephen Fenning

Please note that the questions below are answered to the best of the speaker's knowledge and understanding of the current UK law and professional standards set out by the General Medical Council.

Should end of life be defined by the patient or the clinical team members? Or solely a doctor and if so is that only a consultant?

There are lots of definitions and interpretations of the term 'end of life'. In *'Treatment and care towards the end of life: good practice in decision making'* (General Medical Council, 2010), approaching the end of life is defined as when a person is 'likely to die within the next 12 months'. However, many studies define end of life as within the last 3 or 6 months of life, and, in clinical practice, I often hear colleagues from other specialties reserving the term end of life care for the last weeks of life or when a patient is actively dying.

In my presentation, when discussing withholding and withdrawing treatment/DNACPR at 'end of life', I was not referring specifically to a given timeframe (relative to death) but instead to clinical situations where goals of care are changing (focus on comfort/symptoms rather than cure/treatment) or where the benefit of interventions (relative to their harms) is diminishing. And, if we accept these to be the parameters, I would suggest that anyone involved in the patient's care (including the patient) should feel able to recognise them.

The decisions that then follow should be reached through shared decision-making between the patient and their clinical team – and clearly senior members of the team should be involved at this point, if they have not been already. Some of the clinical decisions that were covered in my presentation (e.g. stopping dialysis; withdrawal of NIV) would require senior doctor/Consultant involvement.

Do you consider use of PCA at end of life to have the patient control the drug dose?

Patient controlled analgesia, though well established in the management of acute pain, tends not to be used at end of life. It is not practical for those wanting to receive end of life care at home or in those whose conscious level is reduced (e.g. the dying patient).

That said, wherever possible, it remains important to give patients control over their analgesia at end of life. In palliative care, this is achieved by regular clinical assessment of symptoms, making shared decisions with patients regarding drug doses and ensuring the patient has reliable access to breakthrough medicines (oral analgesia to be taken 'as required' or, should the oral route no longer be available, staff to give subcutaneous injections).

What is the legal situation if the patient or family insist on DNAR when it is not going to benefit them?

This circumstance is addressed in statements 47-49 and 128-146 in *'Treatment and care towards the end of life: good practice in decision making'* (General Medical Council, 2010):

If you consider that CPR would not be clinically appropriate, you are not obliged to agree to attempt it. You should explain your reasons and any other options that may be available to the patient, including seeking a second opinion.

If, having taken these steps, there is still significant disagreement, you should seek legal advice on applying to the appropriate statutory body for review (Scotland) or appropriate court for an independent ruling. The patient, those authorised to act for them and those close to them should be informed, as early as possible, of any decision to start such proceedings.

Can a patient demand CPR even with co-morbidities and are we supposed to honour it?

The key question to consider here is whether CPR may be successful, rather than whether or not the patient has comorbidities. In many situations, this may seem like an unnecessary distinction to make because clearly CPR is unlikely



to be successful in most patients with several and/or severe long-term health conditions. However, my reason for reframing the question is that the presence of a comorbidity does not in itself mean that CPR always becomes clinically inappropriate and, in some cases, the clinical judgement may be that CPR has a realistic prospect of success and should still be offered.

For a person in whom CPR may be successful, you should make sure that they have accurate information about the nature of CPR interventions and, where possible, the length of survival and level of recovery that they might realistically expect if they were successfully resuscitated. When the benefits, burdens and risks are finely balanced, the patient's request will usually be the deciding factor – and we should respect this.

Conversely, if you consider that CPR would not be clinically appropriate, you are not obliged to agree to attempt it – and a patient cannot 'demand' it from you. You should explain your reasons and any other options that may be available to the patient, including seeking a second opinion.

For further information, see statements 128-146 in *'Treatment and care towards the end of life: good practice in decision making'* (General Medical Council, 2010).

Can a patient or a family agree to DNAR and subsequently change their minds?

The answer to this depends first on whether the patient has capacity and second on whether CPR may be successful.

Patients with capacity (and, by extension, so too the legal proxies of those without capacity) are entitled to change their mind about treatment and care decisions. However, with CPR (as with other medical treatments), if you consider that it would not be clinically appropriate, you are not obliged to provide it.

So, if CPR may be successful and a patient who has previously decided against it now changes their mind to be in favour of it, we should explore the reasons behind the change (to ensure that they are informed and not being coerced) but it is likely that we would respond to this request by reversing the DNACPR decision. However, if CPR would not be successful and a patient who has previously agreed with a DNACPR decision now opposes it, our response should be similar to if they had opposed it from the outset i.e. you should explain your reasons and any other options that may be available to the patient, including seeking a second opinion.

For further information, see statements 128-146 in *'Treatment and care towards the end of life: good practice in decision making'* (General Medical Council, 2010).

How receptive do we think a family member will be, when called at 03:00am to discuss DNACPR for a patient?

Isn't the potential for conflict worse?

This question relates to my discussion of the Carl Winspear case, in which a cardiology registrar did not consult with the mother of a patient who lacked capacity when completing a DNACPR notice at 3am. I agree entirely that discussing DNACPR by phone in the middle of the night is less desirable than meeting with the family in the daytime but, as per the High Court judgement, we have a legal imperative to take into account the views of someone involved in caring for the patient and we cannot use time of day as justification to postpone the conversation. Indeed, in the words of Mr Justice Blake: *'I can see every reason why a telephone call at 3.00am may be less convenient or desirable than a meeting in working hours, but that is not the same as whether it is practicable.'*

It is also worth noting that, in the Winspear case, the claimant (Carl's mother) issued legal proceedings because she had not been consulted about the DNACPR decision nor given the opportunity to represent her son's interests. So, in this situation (as in the Tracey case), the decision not to discuss arguably led to more 'conflict' than if the conversation had taken place at the time.

Finally, remember that, if cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances, it is not necessary to initiate a discussion about CPR.



When CPR is much more likely to cause harm than benefit, but the patient/next of kin strongly resist a DNAR, do you leave it in place pending a second opinion?

To resolve disagreements like this, seek advice or a second opinion as early as possible. Remember that the DNACPR decision only has practical consequence in the event of a cardiorespiratory arrest and so one would hope that, in most cases, clarity and consensus (whether with or without a second opinion) can be achieved well in advance of this situation actually arising.

Assuming that imminent cardiorespiratory arrest is not foreseeable (e.g. the patient is not actively dying), I would be inclined to wait for a second opinion and further discussions before completing the form. To do otherwise may exacerbate the situation, damage relationships and undermine trust, while achieving very little (in that the decision is not actually needing to be resolved in that moment).

The situation is clearly more challenging if a second opinion cannot be obtained promptly and cardiorespiratory arrest is imminent. Here, the care of the patient is our first concern and, if CPR will not work, the DNACPR decision should be made, the reasons explained and the discussions documented.

After a significant event: the review progress – Dr Claire Gordon

Can you please advise where a SAE reviewer refuses to consider important and relevant context to the event? Or does not acknowledge their possible confirmation bias?

I am not sure I understand the question. An SAE reviewer should really review all the information, and then decide what is relevant. It is difficult for me to imagine a scenario where an investigation would refuse to consider relevant and important information. There clearly may be details specific to this case, but it is hard to answer it generically.

How would you advise the maintaining of confidentiality when speaking to non-clinical friends who may share details with others?

Don't. Or make it completely non-identifiable i.e. change the scenario or gender/age. However, generally if you think you are breaching confidentiality or the patient is easily identifiable do not discuss it.

How have you ensured that Nurses have the same approach to SAE as doctors?

We work as a team when it comes to quality improvement, clinical governance and handling complaints and clinical incidents, which definitely helps. However, I have no direct managerial role for the nursing staff so it is mainly done on that team work/good will relationship.