



Neutral Citation Number: [2014] EWCA Civ 822

Case No: C1/2013/0045

**IN THE COURT OF APPEAL (CIVIL DIVISION)**  
**ON APPEAL FROM THE HIGH COURT OF JUSTICE, QUEEN'S BENCH DIVISION**  
**ADMINISTRATIVE COURT**  
**MRS JUSTICE NICOLA DAVIES DBE**  
**[2012] EWHC 3860 (Admin)**

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 17/06/2014

Before:

**MASTER OF THE ROLLS**  
**LORD JUSTICE LONGMORE**  
and  
**LORD JUSTICE RYDER**

Between:

THE QUEEN ON THE APPLICATION OF DAVID TRACEY (PERSONALLY AND ON BEHALF OF THE ESTATE OF JANET TRACEY (DECEASED)) **Appellant**

- and -

CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST **1<sup>st</sup> Respondent**

- and -

SECRETARY OF STATE FOR HEALTH **2<sup>nd</sup> Respondent**

- and -

EQUALITY AND HUMAN RIGHTS COMMISSION **1<sup>st</sup> Intervener**

- and -

RESUSCITATION COUNCIL (UK) **2<sup>nd</sup> Intervener**

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Philip Havers QC, Jeremy Hyam and Kate Beattie (instructed by Leigh Day) for the Appellant

**Lord Pannick QC and Simon Murray** (instructed by **Kennedys**) for the **First Respondent**  
**Vikram Sachdeva** (instructed by **Treasury Solicitor's Department**) for the **Second**  
**Respondent**

**David Wolfe QC** (instructed by **EHRC**) for the **First Intervener**  
**Fenella Morris and Victoria Butler-Cole** (instructed by **Hunters**) for the **Second Intervener**

Hearing dates: 6 & 7 May 2014

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**Judgment Approved by the court**  
**for handing down**  
**(subject to editorial corrections)**

## Master of the Rolls:

### *Overview*

1. This is a claim for judicial review brought by Mr Tracey against the Cambridge University Hospitals NHS Foundation Trust (“the Trust”) and the Secretary of State for Health arising from the placing of Do Not Attempt Cardio-Pulmonary Resuscitation (“DNACPR”) notices on the notes of Mr Tracey’s wife, Janet Tracey, who was admitted to Addenbrookes Hospital (“the Hospital”) on 19 February 2011 and died on 7 March 2011. The Trust is responsible for the Hospital.
2. DNACPR orders are likely to affect most of the population directly or indirectly. According to evidence that we have been shown, 68% of the population die in hospital and 80% of these die with DNACPR notices in place. In other words, in relation to more than 50% of the population, a decision is taken in advance of their deaths that, if they are subject to a cardio-pulmonary arrest, they will not receive cardiopulmonary resuscitation (“CPR”).
3. On 5 February 2011, Mrs Tracey was diagnosed with lung cancer with an estimated life expectancy of 9 months. On 19 February, she sustained a serious cervical fracture after a major road accident. She was admitted to the Hospital and transferred to the Neuro-Critical Care Unit under the care of Mr Peter Kirkpatrick, a consultant neurosurgeon. Because she had chronic respiratory problems she was placed on a ventilator, but did not respond to treatment for her chest infection. On 23 and 25 February, efforts were made to wean her from the ventilator, but these were unsuccessful. On 26 February, her treatment was reviewed by Dr Lavinio, a consultant anaesthetist intensive care specialist, and on 27 February by Dr Ford (a consultant oncologist).
4. It will be necessary to examine the subsequent events in some detail. At this stage, it is sufficient to say that Dr Lavinio and Dr Ford decided that Mrs Tracey should be taken off the ventilator. The question arose as to what would happen if she suffered a cardio-respiratory arrest. On 27 February, Dr Lavinio completed a DNACPR notice (“the first notice”). Mrs Tracey was successfully weaned from the ventilator and her condition appeared to improve. The circumstances in which the first notice came to be completed and placed in her notes lie at the heart of these proceedings. When one of her daughters, Alison Noeland, discovered that the first notice had been made, she was horrified and registered her objections. As a result, the first notice was removed and cancelled on 2 March by Mr Kirkpatrick’s Specialist Registrar, Dr Alavi.
5. On the night of 3-4 March, Mrs Tracey’s health started to deteriorate. She was attended by Dr Simons, a neurological and neuro-critical SHO. Mrs Tracey said that she did not wish to discuss resuscitation. On 5 March, it was agreed with members of the family that a second DNACPR notice (“the second notice”) should be completed and placed on Mrs Tracey’s notes. Dr Simons completed the notice on the same day.

6. Mrs Tracey's condition deteriorated and she died at 10.38 hrs on 7 March.
7. The claim as now advanced against the Trust is that it breached Mrs Tracey's rights under article 8 of the European Convention on Human Rights ("the Convention") because in imposing the first notice, it failed (i) adequately to consult Mrs Tracey or members of her family; (ii) to notify her of the decision to impose the notice; (iii) to offer her a second opinion; (iv) to make its DNACPR policy available to her; and (v) to have a policy which was clear and unambiguous. The claim as now advanced against the Secretary of State is that he breached Mrs Tracey's article 8 rights by failing to publish national guidance to ensure (i) that the process of making DNACPR decisions is sufficiently clear, accessible and foreseeable and (ii) that persons in the position of Mrs Tracey have the right (a) to be involved in discussions and decisions about DNACPR and (b) to be given information to enable them so to be involved, including the right to seek a second opinion.
8. The application for judicial review as originally advanced also included claims that there had been a breach of Mrs Tracey's rights under articles 2 and 3 of the Convention as well as common law claims. These have not been pursued by Mr Havers QC. We are only concerned with article 8.
9. Permission to apply for judicial review was granted by Eady J. Since there was a dispute as to some of the material facts, Ouseley J ordered that there be a fact-finding hearing. This was conducted by Nicola Davies J over a period of six days. She gave a careful and comprehensive judgment on 19 December 2012 [2012] EWHC 3670. In the light of her findings, she ordered that there should be no further hearing of the judicial review proceedings because they had become academic [2012] EWHC 3860. On 24 January 2014, we allowed an appeal against this order for reasons stated in the judgment given by Longmore LJ [2014] EWCA Civ 33. We directed that the judicial review proceedings should be retained in this court. We make it clear that our decision on the judicial review application is a decision of the Court of Appeal and that any appeal lies to the Supreme Court.

#### *What is Cardio-Pulmonary Resuscitation?*

10. CPR was introduced in the 1960s as a treatment that for some people may re-start their heart when they suffer a sudden cardiac arrest due to a heart rhythm disturbance, usually triggered by a "heart attack" (myocardial infarction) from which they would otherwise have been expected to make a good recovery. It is a violent and invasive physical treatment used to attempt to maintain the circulation and breathing of a person whose heartbeat and/or breathing has stopped and to re-start the heart if possible. It involves repeated forceful compression of the bare chest to a depth of 5-6 centimetres at a compression rate of 100-120 per minute, attempted inflation of the lungs by forcing air or oxygen into the lungs often through a tube inserted into a patient's windpipe, the injection of drugs into veins or into bones and the delivery of high-voltage electric shocks (defibrillation) across the bare chest. In his witness statement, Doctor David Pitcher, the chairman of the Resuscitation Council (UK),

states that, in contrast to the relatively good outcomes from sudden cardiac arrest due to heart attack, in people whose heartbeat and breathing stop because of other serious health problems (including advanced cancer), the chance of CPR being successful and allowing recovery to hospital discharge is very much lower. For example, he says that the likelihood of a cancer patient on a critical care unit having a successful CPR has been reported at only 2.2%. However, it would be expected that even this rare success would be limited to those few people without advanced cancer and without severe disease of any major organs.

*The facts in more detail*

11. As the judge recorded at para 21 of her judgment, it was the evidence of family members that Mrs Tracey “was engaged with issues of care during her stay in hospital, she would ask what was going on, being quite medically minded from her work she wanted to know about the drugs, the equipment and what the nurses were doing”. She communicated with the staff by writing on a pad or by whispering.
12. On 26 February, Mrs Tracey was reviewed by Dr Lavinio. His plan was to keep Mrs Tracey intubated. Her condition was deteriorating despite maximal medical treatment. Dr Lavinio spoke to Alison Noeland to express his concern. She confirmed to him her understanding that her mother’s wish was to receive full active treatment. Dr Lavinio’s note in the medical records included a reference to his understanding that Mrs Tracey’s “wish would be to receive full active treatment”.
13. Dr Ford saw her on 27 February. It was his opinion that she would never be fit enough to receive chemotherapy; the best case scenario was a life expectancy of a few months, but her life expectancy was worse because of her chest infection/pneumonia, which was not responding to treatment, and the fact that she was immobile by reason of her cervical fracture. Dr Ford’s entry in the medical records reflected her “clear wish” to be involved in discussions. Alison was present during this consultation. She said that Dr Ford told Mrs Tracey that tough decisions would have to be made. In response, Mrs Tracey wrote a note stating “please do not exclude me” and “I will do my damdest”.
14. It was Dr Lavinio’s evidence that he broached the issue of DNACPR with Mrs Tracey, explained what it meant and that she nodded to indicate her agreement to it. He then completed the first notice.
15. Mrs Tracey was successfully weaned from the ventilator. On the following day, she was able to sit up in bed, eat and drink. Alison felt sufficiently comfortable about her mother’s condition to return to Norway. Following her return to Norway, she did some research on the internet. She was horrified to discover what DNACPR meant, as this was against the wishes of Mrs Tracey and the family. She telephoned the

Hospital and told the nurse to whom she spoke that neither Mrs Tracey nor the family had agreed to DNACPR.

16. Mr Kirkpatrick was contacted by Dr Alavi on 2 March and informed that objections had been raised by Alison to the DNACPR notice. He authorised its removal pending discussions with the family. Dr Alavi made an entry in the medical records dated 2 March, timed 10.30 hrs. It reads:

“Her daughter Alison Noland (sic) has contacted Mikki, our  
CNP and expressed her objection against DNACPR.

I D/W patient & she is also against DNACPR & wants to be  
resuscitated in case of cardio-respiratory arrest.

I D/W PJK ---for resuscitation, DNACPR to be removed.”

17. Dr Alavi wrote on the notice the words

“Cancelled

Ali Alavi

Because of patient wish and her daughter wish”.

18. On 1 March, Mrs Tracey was transferred to Ward A5 and the Palliative Care Team became involved in her care. On the following day, Sue Sharpe, the clinical nurse specialist, made a note recording that Mrs Tracey had declined DNACPR but “states that she does not really understand this and needs further discussion”.
19. On 4 March, she was reviewed by Dr Simons who had not seen Mrs Tracey for a few days and was concerned at her deterioration. Dr Simons said that Mrs Tracey did not wish to engage in discussions about her care and prognosis. Every time she initiated a discussion about resuscitation, Mrs Tracey would either say that she did not wish to discuss the issue or that she would speak to her family about it.
20. It is unnecessary to describe the detail of the subsequent events leading to Mrs Tracey’s death on 7 March, since it is not material to the issues that we have to decide.

*The judge’s key findings in relation to the first notice*

21. At para 110 the judge accepted that it was the intention of Dr Lavinio to inform Alison that resuscitation was not appropriate, but said:

“whether in a wish to spare her the harshness of a graphic explanation of CPR or a belief that in using words such as ‘slip away’ he was conveying the entirety of such a scenario, I believe that the entirety of the position was not fully understood by Alison.”

22. The judge also accepted at para 112(iii) that Dr Lavinio believed that he had “conveyed the resuscitation issue including the use of the DNACPR notice to Alison who understood and agreed with it”. The judge then said:

“115 There is nothing in the medical/nursing records which suggests any agreement to DNACPR by Mrs Tracey. The tenor of entries prior to 4 March 2011 indicate that Mrs Tracey either did not agree or requested that any such discussion take place in the presence of her husband or daughters. If Dr Lavinio had such a conversation, it would have been of importance to note the same both on the DNACPR Notice and in the medical records. I am unable to accept that the absence of such a note is a result of no more than poor record keeping.

116 I do not doubt Dr Lavinio's real concern for his patient, nor his wish to spare her an undignified procedure which he, and other clinicians, believed to be of no clinical benefit. It may well be that such a concern also caused him to spare her a conversation which he knew was likely to cause distress to a suffering patient. In the absence of any documentation and in the light of what is known about Mrs Tracey's view on the issue of resuscitation around the time of the first Notice, I am unable to accept Dr Lavinio's evidence that he spoke to Mrs Tracey about resuscitation prior to the implementation of the first DNACPR Notice.”

*Did Mrs Tracey wish to be consulted about the first DNACPR?*

23. Lord Pannick QC submits that Mrs Tracey did not wish to discuss the issue of resuscitation and that she told the clinicians that this was her position at the time of the first notice as well as the second notice. I should make it clear that it is common ground that she did not wish to discuss the issue by the time when the second notice was placed on her notes.
24. In support of his submissions, Lord Pannick relies on references by the judge at paras 63 and 92 to the evidence of Dr Simons leading to the finding at para 118 that:

“Given the evidence, in particular of Dr Simons, I accept that her prognosis was not a matter which Mrs Tracey wished to discuss.”

25. He submits that, if Mrs Tracey did not wish to discuss her prognosis with Dr Simons (described by one of her daughters, Kate Masters, as “sympathetic and a good communicator”) there is every reason to think that she was not willing to discuss it with any other doctor. Indeed, according to the evidence of Mr Tracey (para 57 of the judgment), Mrs Tracey felt “badgered” by the attempts of the doctors to discuss her end of life treatment with her.
26. Lord Pannick also draws attention to passages at paras 4, 9, 11, 13 and 14 of the witness statement of Dr Simons. For example, at para 11 she says:
- “Mrs Tracey did not wish to engage in discussion relating to her care and prognosis. On occasions when I attempted to initiate discussions with Mrs Tracey regarding her treatment and her future she did not want to discuss these issues with me.”
27. Lord Pannick points out that Dr Simons does not confine this evidence to the period after the first notice was cancelled. He submits that Dr Simons should be understood as referring to the entire period during which Mrs Tracey was under her care.
28. It is true that Dr Simons does not state in terms that she is referring only to the period after the cancellation of the first notice. But in my view, these passages in her evidence are too slender a foundation on which to base a finding that Mrs Tracey did not wish to be involved in the decision to complete the first notice. The passages in paras 63 and 92 of the judgment on which Lord Pannick relies undoubtedly relate to the second notice. The factors which show that Mrs Tracey unquestionably did want to be involved in the first notice are the matters to which I have referred at paras 16 and 17 above, in particular the notes of Dr Alavi. I am satisfied that Mrs Tracey did wish to be consulted about any DNACPR notice that the clinicians were contemplating completing and placing in her notes up to the time of the first notice.

*Was article 8 engaged?*

29. Mr Havers QC submits that article 8 is engaged by a DNACPR decision because it concerns how an individual chooses to pass the closing days and moments of her life and how she manages her death: see *Pretty v UK* (2002) 35 EHRR 1 at paras 61, 64 and 67. It is a decision which concerns a patient’s personal autonomy, integrity, dignity and quality of life. There is a clear and consistent line of Strasbourg jurisprudence to the effect that, although article 8 contains no explicit procedural requirements, the decision-making process which leads to measures of interference with an individual’s right to private life must be fair and such as to afford due respect to the interests safeguarded by article 8. The purpose of implying a procedural obligation is to ensure “effective” respect for the right. Thus in *Tysiac v Poland* (2007) 45 EHRR 42, the ECtHR said at para 115:

“Finally, the Court reiterates that in the assessment of the present case it should be borne in mind that the Convention is



intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective. Whilst Art.8 contains no explicit procedural requirements, it is important for the effective enjoyment of the rights guaranteed by this provision that the relevant decision-making process is fair and such as to afford due respect to the interests safeguarded by it. What has to be determined is whether, having regard to the particular circumstances of the case and notably the nature of the decisions to be taken, an individual has been involved in the decision-making process, seen as a whole, to a degree sufficient to provide her or him with the requisite protection of their interests.”

30. Lord Pannick does not seriously dispute that article 8 is engaged, but Mr Sachdeva on behalf of the Secretary of State does. Mr Sachdeva submits that there is no authority to support the view that article 8 is engaged by a decision not to resuscitate and that it is simplistic to apply what was said in cases such as *Pretty* in the present context. Thus, for example, it does not follow from the fact that article 8 is engaged where an individual wishes to be assisted to commit suicide so as to avoid an undignified end to his life that it is also engaged where an individual wishes to prolong his life by having medical treatment. He submits that it is not sufficient to say that article 8 is engaged simply because the decision which is under consideration impacts on the physical integrity and autonomy of an individual. But he has been unable to identify the criteria by which to determine whether article 8 is engaged by the withholding of medical treatment. He submits that the court should not hold that article 8 is engaged in situations in which the ECtHR has not yet decided that it is engaged and refers to what Lord Bingham said in *R (Ullah) v Special Adjudicator* [2004] UKHL 26, [2004] 2 AC 1 at para 20 and to various passages in *Ambrose v Harris* [2011] UKSC 43, [2011] 1 WLR 2435. Mr Sachdeva also relies on the decision of this court in *R (on the application of Condliff) v North Staffordshire Primary Health Care Trust* [2011] EWCA Civ 910, [2012] 1 All ER 689 in support of his case that article 8 is not engaged here.
31. I accept Mr Sachdeva’s submission that what is required by respect for an article 8 right is highly contextual. As the ECtHR said in *Goodwin v United Kingdom* (2002) 35 EHRR 447 at para 72, the notion of “respect” as understood in article 8 is “not clear cut”, especially so far as the positive obligations inherent in the concept are concerned. The court said: “the notion’s requirements will vary considerably from case to case and the margin of appreciation to be accorded to the authorities may be wider than that applied in other areas under the Convention”: see also *Tysiac* at para 114. I also accept the submission of Mr Sachdeva that there is no positive article 8 obligation to ensure access to resuscitation. But Mr Havers does not contend that there is such an obligation.
32. In my judgment, however, none of Mr Sachdeva’s submissions justifies the conclusion that article 8 is not *engaged* by a decision to impose a DNACPR notice. A decision as to how to pass the closing days and moments of one’s life and how one manages one’s death touches in the most immediate and obvious way a patient’s

personal autonomy, integrity, dignity and quality of life. If there were any doubt as to that, it has been settled by the decision in *Pretty*.

33. It is true that there is no authority which has specifically decided that it is so engaged in the particular context with which we are concerned, but there is no contrary authority either. I do not accept that decisions such as *Ullah* and *Ambrose* require this court to hold that article 8 is not engaged simply because there is no Strasbourg authority which says that it is engaged in a case such as this.
34. In fact, *Glass v UK* (2004) 39 EHRR 15 does shed some light on the view of the ECtHR on the point. The applicants complained that UK law and practice breached the first applicant's article 8 rights in that decisions were made by hospital doctors (i) to administer diamorphine against his mother's wishes and (ii) to place a DNACPR notice in his notes without her knowledge. The court decided the first complaint in favour of the applicants. At para 83, it said:

“In view of that conclusion, it does not consider it necessary to examine separately the applicants' complaint regarding the inclusion of the DNR notice in the first applicant's case notes without the consent and knowledge of the second applicant. It would however observe in line with its admissibility decision that the notice was only directed against the application of vigorous cardiac massage and intensive respiratory support, and did not exclude the use of other techniques, such as the provision of oxygen, to keep the first applicant alive.”
35. It is of note that it appears not to have been in dispute that article 8 was engaged. If it had not been engaged, that would have been a complete answer to the complaint and one would have expected the court to say so. Indeed, if article 8 was not engaged by the placing of a DNACPR notice, it is difficult to see why it was also not engaged by the decision to administer diamorphine against the mother's wishes. Yet the court proceeded on the basis that article 8 was engaged both in relation to the decision to administer diamorphine and in relation to the DNACPR issue.
36. In *Tysiac*, the applicant suffered from severe myopia and was worried about the possible impact on her health of her pregnancy. She wished to have an abortion. The hospital doctor said that there were insufficient grounds for a termination. After the delivery, her eyesight deteriorated. She lodged a criminal complaint against the doctor, but the prosecutor discontinued the investigation on the basis that there was no case to answer. Her appeal was dismissed and her attempt to bring disciplinary proceedings against the doctor was unsuccessful. She made a number of complaints to the ECtHR. These included a complaint that there had been a breach of her article 8 rights by failing to provide her with an abortion and by the absence of a comprehensive legal framework to guarantee her rights by appropriate procedural means. Her complaint was upheld by the court.
37. At para 109, the ECtHR said:

“The Court also reiterates that “private life” is a broad term, encompassing, inter alia, aspects of an individual’s physical and social identity including the right to personal autonomy, personal development and to establish and develop relationships with other human beings and the outside world. Furthermore, while the Convention does not guarantee as such a right to any specific level of medical care, the Court has previously held that private life includes a person’s physical and psychological integrity and that the State is also under a positive obligation to secure to its citizens their right to effective respect for this integrity.”

38. Similar statements appear in many of the Strasbourg cases. It was not in dispute that article 8 was engaged in that case and at para 108 the court recorded its agreement that it was engaged. It reiterated that “legislation regulating the interruption of pregnancy touches upon the sphere of private life, since whenever a woman is pregnant her private life becomes closely connected that of the developing foetus”.
39. The question whether a woman is permitted by the state to have an abortion clearly raises issues concerning her private life in the broad sense. It touches her right to personal autonomy. Article 8 was held to be engaged in *Tysiack* notwithstanding the fact that the right to private life could not be interpreted as conferring a right to an abortion. The fact that the court has held that article 8 is engaged in abortion cases (*RR v Poland* (2011) 53 EHRR 31 is another example) supports the conclusion that it is engaged in a case concerning DNACPR notices.
40. Next, I need to deal with *Condliff*. The defendant primary care trust had a policy for commissioning bariatric surgery. A certain form of bariatric surgery was appropriate for the claimant, but he did not come within the scope of the general policy. His claim for treatment was rejected. He claimed that the trust owed a positive duty under article 8 to consider his private and family life. His claim was dismissed by this court. Toulson LJ said at para 35 that the issue was whether “article 8 makes it unlawful for a PCT (Primary Care Trust) to adopt an IFR (individual funding request) policy by which IFRs are to be considered and determined solely by reference to clinical factors”. He reviewed some of the jurisprudence, particularly in relation to the difference between prohibiting interference with an individual’s private and family life and imposing positive obligations on the state. At para 41, he noted that, although the ECtHR has recognised that in principle article 8 may be relied on to impose a positive obligation on a state to provide support for an individual including medical support, there is no reported case in which the court has upheld a claim by an individual complaining of the state’s non-provision of medical treatment. Finally, at para 52 he said:

“Nothing in the authorities therefore leads me to conclude that the policy of the PCT, properly understood, is to be regarded as showing a lack of respect for Mr Condliff’s private and family life so as to bring art 8 into play. If, however, art 8 is applicable, there were legitimate equality reasons for the PCT

to adopt the policy that it did and its decision was well within the area of discretion or margin of appreciation properly open to it.”

41. I do not read Toulson LJ as saying that article 8 was not *engaged*. Although the use of the words “into play” and “applicable” might suggest that he was saying that article 8 was not engaged, that would be difficult to reconcile with what he said at para 41 which seemed to proceed on the basis that article 8 was engaged in the cases to which he was referring . Nor would it sit well with his saying at para 52 itself that nothing in the authorities leads to the conclusion that the policy “is to be regarded as showing a lack of respect for Mr Condliff’s private and family life so as to...”. The better interpretation is that he was saying that there was nothing in the authorities which would support the conclusion that there had been an interference with the right to private life granted by article 8(1); but if there had been an interference, it was justified under article 8(2). I would add that, if my interpretation of para 52 is wrong, then I respectfully disagree with it. It is clearly not the law that article 8 is never engaged in any case involving the provision or withholding of medical treatment.
42. The question whether article 8 is *engaged* should not be confused with the separate question of whether it is breached in the circumstances of any particular case. It is not necessary for the purpose of deciding the issues that arise in this case to decide the full reach of article 8 in relation to the withholding of medical treatment. Mr Havers confines himself to submitting that article 8 is engaged whenever a DNACPR order is in contemplation because, if an order is made, it is likely directly to affect how the patient will end his or her life. DNACPR decisions should be distinguished from other decisions to withhold life-saving treatment because they are taken in advance and therefore they present an opportunity for discussion with patients and their family members.
43. Finally, I should emphasise that the claimant in the present case is not complaining about the substantive decision to withhold CPR. It is about aspects of the procedure which led to the making of the decision and aspects of the policy which governs the making of DNACPR decisions.
44. With this introduction, I must now turn to the case against the Trust and the Secretary of State.

*The clinicians' obligation to involve the patient in a DNACPR decision*

45. Mr Havers submits that clinicians should adopt measures to ensure that a patient of capacity who is in the position that Mrs Tracey was in at the time of the first notice is involved in the process which leads to the making of a DNACPR decision; and that if the patient is not willing or able to be involved, members of her family should be involved. He says that, unless it is obviously inappropriate to do so, the patient (or members of the family) should be consulted when the notice is being considered, her (or their) views should be sought by the doctors and if a notice is imposed, she (or they) should be told about it. He submits that these measures are required by a fair process. Anything less is insufficient to guarantee due respect for the interests safeguarded by article 8.
46. Lord Pannick agrees that there should be patient involvement in the decision-making process unless this is inappropriate, but he does not accept that there must be involvement unless it is *obviously* inappropriate. He submits that it is not appropriate to consult if the clinician forms the view that CPR would be futile or that it would cause harm or distress to the patient to be informed and involved in the process.
47. The question of the circumstances in which it is appropriate for a clinician to consult the patient about a DNACPR decision has been the subject of careful consideration by the medical profession for some time. There has been a growing recognition of the importance of involving patients in decisions which potentially deprive them of life-saving treatment. For example, the October 2007 version of the Joint Statement "Decisions relating to cardiopulmonary resuscitation" by the Royal College of Nursing, the Resuscitation Council (UK) and the BMA ("the Joint Statement") states in its introduction:
- "Some health professionals do not find it easy to discuss CPR with their patients, but this must not prevent discussion, either to inform patients of a decision or involve patients in the decision-making process, where appropriate."
48. Paragraph 6.1 states:
- "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 discussion with the patient to explore their wishes regarding CPR.
- Careful consideration should be given as to whether or not to inform the patient of the decision. Although patients should be helped to understand the severity of their condition, whether they should be informed explicitly of a clinical decision not to attempt CPR will depend on the individual circumstances. In most cases a patient should be informed, but for some patients, for example those who know that they are approaching the end

of their life, information about interventions that would not be clinically successful would be unnecessarily burdensome and of little or no value. Others indicate by their actions and involvement in decision-making that they want detailed information about their care and want to be fully involved in planning for the end of their life. Therefore an assessment should be made of how much information the individual patient (or, if the patient lacks capacity, those close to them) wants to know. The decision must be the one that is right for the patient and information should never be withheld because conveying it is difficult or uncomfortable for the healthcare team. In considering this clinicians need to take account of the fact that patients are legally entitled to see and have a copy of their health records, so it may be preferable for them to be informed of the existence of a DNAR decision and have it explained to them rather than for them to find it by chance. It may be distressing to them to find out by chance that a DNAR decision has been made without them being involved in the decision or being informed of it. ”

49. The Trust’s policy includes the following:

**“6. When to consider a DNACPR order**

A DNACPR decision should only be made after appropriate consultation and consideration of all aspects of the patient’s condition. Decisions must be taken in the best interest of the patient, following assessment that should include likely clinical outcome and the patient’s known or ascertainable wishes.

**6.1 DNACPR decisions for adults**

It is appropriate to consider implementing a DNACPR order where:

- the patient’s condition indicates that effective CPR is unlikely to be successful.
- CPR is not in accord with the recorded, sustained wishes of a patient who is mentally competent
- CPR is not accordance with a valid applicable advance directive (anticipatory refusal or living will). For further information please refer to the Trust’s advance statements,

advance decisions and lasting powers of attorney in relation to future medical treatment policy

- successful CPR is likely to be followed by a length and quality of life which it would not be in the best interests of the patient to sustain.

### **7.1 Patient rights**

The rights of the patient are absolute to any decision making regarding resuscitation. The patient's rights must be respected, and where clinically possible, patients should be consulted in advance as to who they want, or do not want, to be involved in decision making if they became incapacitated.

### **7.3 Discussion with relatives**

Any discussion with relatives or close friends (if appropriate and with due regard to patient confidentiality) may be valuable in assisting with the decision. However, the final decision rests with the clinician – relatives cannot determine a patient's best interests, nor give consent to, nor refuse treatment on a patient's behalf unless acting under an LPA (see above). They should be assured however that their views will be taken into account.”

50. We have had detailed submissions as to the circumstances in which it is appropriate for a clinician not to consult the patient about a DNACPR decision. Mr Wolfe QC, for The Equality and Human Rights Commission, emphasises the difference between (i) medical issues (such as whether CPR might work) which are matters for the clinicians to decide and (ii) questions relating to the welfare of the patient in the widest sense (including social and psychological issues) which are essentially for the patient to decide. It is for the patient and not for others to say that a life which the patient would regard as worthwhile is not worth living: see *Aintree University Hospitals Trust v James* [2013] UKSC 67, [2013] 3 WLR 1299 at paras 40 to 44.
51. Ms Morris QC and Victoria Butler-Cole, for the Resuscitation Council (UK), submits that it is wrong to draw a distinction between cases in which CPR will be “mechanically unsuccessful” (i.e. the heart will not be restarted) and all other cases and on the basis of this distinction to say that it is inappropriate to consult only in the former. She says that CPR is also unsuccessful in circumstances where it will merely prolong the dying process for a matter of hours or days. CPR can properly be considered to be “futile” in such circumstances. In both cases, attempting CPR will

violate the clinician's fundamental professional obligation to do no harm, and cannot be required of a clinician, whatever the patient's wishes. In both cases, therefore, it is not necessary to consult the patient about a DNACPR decision.

52. In my view, the court should be slow to give general guidance as to the circumstances in which it is not appropriate to consult a patient in relation to a DNACPR decision. As the ECtHR said in *Tysiack* at para 115, the degree of patient involvement required by article 8 depends on "the particular circumstances of the case and notably the nature of the decisions to be taken". The salutary warning given by Lord Phillips MR giving the judgment of this court in *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, [2006] QB 273 at para 21 should be borne in mind. He said:

"There are great dangers in a court grappling with issues such as those that Munby J has addressed when these are divorced from a factual context that requires their determination. The court should not be used as a general advice centre. 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."

53. But I think it is right to say that, since a DNACPR decision is one which will potentially deprive the patient of life-saving treatment, there should be a presumption in favour of patient involvement. There need to be convincing reasons not to involve the patient.
54. There can be little doubt that it is inappropriate (and therefore not a requirement of article 8) to involve the patient in the process if the clinician considers that to do so is likely to cause her to suffer physical or psychological harm. There was some debate before us as to whether it is inappropriate to involve the patient if the clinician forms the view that to do so is likely to distress her. In my view, doctors should be wary of being too ready to exclude patients from the process on the grounds that their involvement is likely to distress them. Many patients may find it distressing to discuss the question whether CPR should be withheld from them in the event of a cardio-respiratory arrest. If however the clinician forms the view that the patient will not suffer harm if she is consulted, the fact that she may find the topic distressing is unlikely to make it inappropriate to involve her. I recognise that these are difficult issues which require clinicians to make sensitive decisions sometimes in very stressful circumstances. I would add that the court should be very slow to find that such decisions, if conscientiously taken, violate a patient's rights under article 8 of the Convention.
55. Lord Pannick submits that it is also inappropriate to involve the patient if the clinician forms the view that CPR would be futile even if he considers that involvement is unlikely to cause the patient harm. I would reject this submission for two reasons. First, 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. It calls for particularly convincing justification. Prima facie, the patient is entitled to know that such an important clinical decision has been taken. The fact that the clinician considers that CPR will not work means that the patient cannot require him to provide it. It does not, however, mean that the patient is not entitled to know that the clinical decision has been taken. Secondly, if the patient is not told that the clinician has made a DNACPR decision, he will be deprived of the opportunity of seeking a second opinion. The desirability of affording the patient the opportunity of seeking a second opinion is recognised in the Joint Statement (see para 61 below) and in the authorities (see para 63 below).

*Was there a breach of the duty to consult and notify in relation to the first notice?*

56. Was it inappropriate to consult in relation to the first notice on the facts of this case? Lord Pannick submits that Dr Lavinio was entitled in the exercise of his clinical judgment to decide not to consult Mrs Tracey on the grounds that (i) he believed that CPR would be futile and (ii) he knew that it would cause her distress to be involved in a discussion as to whether she should be resuscitated in the event of a cardio-respiratory arrest. I have already dealt with the futility point. Lord Pannick relies on para 116 of the judgment (see para 22 above) in support of his submission in relation to the distress point. There are two answers to this submission. First, a belief that it would cause distress to the patient to discuss the issue is unlikely to be sufficient, without more, to make it inappropriate to involve her. The distress must be likely to cause the patient a degree of harm. There is no finding as to the nature of the distress that Dr Lavinio believed Mrs Tracey would be likely to suffer or the harm that it might cause. I accept at once that, if Dr Lavinio had given evidence that he did not discuss CPR with her because he thought that she would be distressed and that this might cause her harm, the court would have been most unlikely to interfere with his clinical judgment. In that event, the court would have concluded that the clinician was entitled to decide that it was inappropriate to involve her in the process. The difficulty in this case is that Dr Lavinio gave no such evidence. His case was that he *did* discuss the matter with Mrs Tracey. In truth, Lord Pannick's submission is an artificial construct based on a reading of para 116 which does not take account of the crucial fact that Dr Lavinio insisted that he spoke to Mrs Tracey about the DNACPR issue.
57. However, Lord Pannick has another string to his bow. Basing himself on para 115 of *Tysiac*, he submits that the question is whether Mrs Tracey was "involved in the decision-making process seen as a whole" to a degree sufficient to provide the requisite degree of protection of her interests. The whole history from 19 February (when Mrs Tracey was admitted to the Hospital) until 7 March (when she died) must be taken into account. He draws particular attention to the fact that (i) the first notice was only in operation for three days; (ii) Mr Kirkpatrick cancelled it as soon as the family expressed their concern about it pending further discussions with them about it; (iii) there were then extensive attempts to consult Mrs Tracey in circumstances of great difficulty which are described in detail by the judge; and (iv) the second notice was imposed after consultation with the family and with their agreement. Looked at as a whole, he submits, this shows that the clinicians were a dedicated medical team who showed proper respect for the article 8 rights of Mrs Tracey.

58. At first sight, this seems an attractive argument. But I cannot accept it. The relevant “decision-making process seen as a whole” was the process which led to the decision which was taken without consultation, i.e. the decision to impose the first notice. The fact that the second notice was imposed after proper consultation does not make good the shortcomings in the process which led to the making of the first DNACPR decision. It is fortuitous that the first notice was cancelled after only three days. It is also fortuitous that Mrs Tracey did not suffer an arrest whilst the notice was in operation. In my view, this fortuity cannot bear on the question whether Mrs Tracey was sufficiently involved in the decision-making process which led to the imposition of the first notice.
59. It follows that in my view there was a breach of the article 8 procedural obligation to involve Mrs Tracey before the first notice was completed and placed in her notes. The Trust has not demonstrated that there were convincing reasons in this case not to consult her before this step was taken.

*The second opinion point*

60. Mrs Tracey was not offered the opportunity to obtain a second opinion by the Trust when it imposed the first or the second notice. Mr Havers submits that this amounted to a breach of article 8, although we are only concerned with the first notice on this appeal. He says that this issue arises because the possibility of a second opinion might have been raised if Mrs Tracey had been consulted and if there had been disagreement as to whether a DNACPR decision should be made. In my view, that possibility is not sufficient for the issue to arise on the facts of this case. It would only arise if there were a disagreement between patient and doctor or if there were a disagreement between the treating doctors themselves. Nevertheless, we heard argument on the question whether article 8 can require a second medical opinion to be offered in the event of disagreement.
61. The Joint Statement states at para 7.2:
- “Doctors cannot be required to give treatment contrary to their clinical judgement, but should be willing to consider and discuss patients’ wishes to receive treatment, even if it offers only a very small chance of success or benefit. Where attempted CPR has a reasonable chance of successfully re-starting the heart and breathing for a sustained period, and patients have decided that the quality of life that can reasonably be expected is acceptable to them, their wish for CPR should be respected. In the unusual circumstance in which the doctor responsible for a patient’s care feels unable to agree to the patient’s expressed wishes for attempted CPR, or where there is a lack of agreement within the healthcare team, seeking a second opinion is recommended so that patients may be given an opportunity to review their decision in the light of further advice. Transfer of the patient’s care to another doctor or team

can be considered if there is still a lack of agreement and it is feasible. In exceptional circumstances, where there is ongoing disagreement, it may be necessary to seek legal advice.”

62. The Trust’s policy that was in force in 2011 did not contain any reference to the offer of a second opinion. The Trust has, however, for some time been working on the text of a leaflet to hand to patients entitled “Talking to your doctor about treatments: a guide for patients”. Since 29 April 2014, a standard form of leaflet has been issued to all patients. Page 4 includes: “If you (or your relative) don’t think the doctor has made the right choice about a treatment they can ask for a second doctor to assess this (this is called a **second opinion**)”.
63. Reference has been made to *Burke* where Lord Phillips endorsed a number of propositions including at para 50 (v) that, if the doctor concludes that the form of treatment requested by the patient is not clinically indicated, he is under no legal obligation to provide it to the patient “although he should offer to arrange a second opinion”. It is not clear whether Lord Phillips meant that the doctor is under a *legal obligation* to offer to arrange a second opinion or whether he should do so as a matter of good practice. Either way, what he said about second opinions was not part of the ratio of the decision. Without the benefit of full argument on the point, I would be reluctant to hold that a doctor is under a legal obligation to offer to arrange a second opinion in all circumstances. I accept that there is some support for the existence of such a duty in *Re B (adult: refusal of treatment)* [2002] EWHC 429 (Fam), [2002] 2 FCR 1 at para 100 (viii). This may, however, be no more than an application of the usual duty of care owed by all treating doctors to their patients.
64. More importantly, whether a doctor is under a legal obligation to offer to arrange for a second opinion or not, I can see no basis for holding that article 8 requires him to do so. I do not consider that the availability of a second opinion is one of the core procedural safeguards protected by article 8. Unlike the rights to notification and consultation, which respond directly to the value of patient autonomy, an interpretation of article 8 which includes the right to a second medical opinion would represent an unacceptable intrusion into the realm of clinical judgment.
65. In any event, I would accept the submission of Lord Pannick that there is no obligation to offer to arrange a second opinion in a case, such as that of Mrs Tracey, where the patient is being advised and treated by a multi-disciplinary team all of whom take the view that a DNACPR notice is appropriate.

*Availability of a sufficiently clear and precise policy*

66. Article 8(2) requires any interference with an individual’s rights under article 8(1) to be “in accordance with the law”. This requires the policy which describes the circumstances in which the Trust’s clinicians may interfere with a patient’s article 8(1) rights to be accessible and clear. In *Purdy v DPP* [2009] UKHL 45, [2010] 1 AC 345, Lord Hope said at para 40 that any interference with article 8(1) rights must meet

the threshold requirements of being “sufficiently accessible to the individual who is affected” and “sufficiently precise to enable him to understand its scope and foresee the consequences of his action”. In my view, an advance DNACPR decision would not satisfy these criteria if it was not made in accordance with a clear and accessible policy. The right to be consulted and notified about DNACPR decisions would be undermined if the patient was not aware of the criteria by which the clinician reached the decision to complete a DNACPR notice.

67. I start with accessibility. The Trust’s policy was available on-line at the time when Mrs Tracey was admitted to the Hospital. As the judge found at para 15 of her judgment, it was intended to provide guidance to clinicians on the issue of resuscitation and the initiation of DNACPR notices. It was not directed to patients. Nor was it disseminated to patients unless specifically requested. A copy was not provided to Mrs Tracey or members of her family. In 2011, the Trust did not comply with the recommendations of the Joint Statement which stated at para 12:

“Written information about CPR policies should be included in the general literature provided to patients about healthcare organisations.....The BMA has produced a model patient information leaflet addressing some of the common questions that patients ask or may want to ask....Such information should be readily available to all patients and to people close to the patient including relatives and partners. Its purpose is to demystify the process by which decisions are made....Information should reassure patients of their part in the decision-making, what facilities are available, and where it is likely that CPR would be successful”.

68. The BMA model patient information leaflet dated April 2008 states under the heading **“Will I be asked whether I want CPR?”** :

“You and the healthcare professional in charge of your care will decide whether CPR should be attempted if you have a cardio-respiratory arrest....Your wishes are very important in deciding whether resuscitation may benefit you, and the healthcare team will want to know what you think.”

69. It would appear that the Trust has now recognised the lack of accessibility of its previous policy. Since 29 April 2014, it has been issuing to patients a leaflet entitled “Talking to your doctor about treatments: a guide to patients” which summarises the policy in a manner which, in my judgment, is sufficiently accessible for the purposes of article 8(2). It explains what CPR is. It states that:

“[y]our doctor will probably ask you if you want to be given all the treatments that they think would help you. This is an opportunity to tell your doctor what is most important to you when you are treated in hospital”.

70. It also states that the doctors need to work out which treatments are possible and medically best for the patient and that when they make these decisions they will always consider what the patient wants.
71. With effect from 29 April 2014, there is also to be found on the Trust's website its Universal Form of Treatment Options ("UFTO") Guidance which is entitled "Information for Patients, relatives and staff". This states under the heading "**When should a decision not to attempt CPR be considered?**":
- "A decision that CPR should not be attempted should only be made after appropriate consultation and consideration of all aspects of the patient's condition. Decisions must be taken in the best interests of the patient, following assessment that should include likely clinical outcome and the patient's known or ascertainable wishes."
72. In my view, the Trust's leaflet (together with the UFTO Guidance) makes good the previous shortcomings in the accessibility of its policy. In these circumstances, I see no need to grant a declaration (as sought by Mr Havers) that it should have an accessible policy including details of the patient's right to be consulted prior to a DNACPR notice being placed in the notes.
73. I turn to the question whether the Trust's policy was sufficiently clear. In his oral submissions, Mr Havers has confined himself to a single criticism. He submits that there is an inconsistency between paras 7.1 and 7.3 of the policy (see para 49 above). He accepts that para 7.3 states unequivocally that the final decision regarding resuscitation rests with the clinician. But he submits that this is inconsistent with para 7.1 which states that the rights of the patient are "absolute", since, he says, the use of the word "absolute" suggests that it is the patient who has the final word. I cannot accept this interpretation of para 7.1. Para 7.1 itself says that the patient should be consulted "where clinically possible". What is meant by para 7.1 is that such rights as the patient enjoys must be respected and are absolute. But para 7.3 makes it clear that those rights are subject to the right of the clinician to have the last word. In my view, this criticism of the policy is unfounded.

#### *THE CASE AGAINST THE SECRETARY OF STATE*

74. Mr Havers submits that there has been a breach of article 8 in that the state failed to comply with its positive obligation to secure to Mrs Tracey effective respect for her right to private life by failing to promulgate national guidance which is clear and directed at patients. He says that the need for such national guidance is demonstrated by the fact that (i) local policies say different things as to what "rights" (if any) a patient has to be notified and consulted about a DNACPR decision, including the right to a second opinion; (ii) the Joint Statement, which is addressed to professionals but not patients, does not make clear to patients what their rights are with respect to DNACPR decisions—indeed, it suggests that patients have no right to be informed of a DNACPR decision, if the treating clinician considers that CPR has no prospect of

success; (iii) the Joint Statement is unclear as to when treatment is or is not “futile”, or when a clinician is entitled to consider “effective CPR is unlikely to be successful”; (iv) there is a great deal of evidence from throughout the country which shows that DNACPR procedures are poorly understood and applied; and (v) the stated position of the Parliamentary Under-Secretary of State on 28 February 2014 appeared to deny the right of a patient to be involved in the imposition of a DNACPR notice provided that the doctors can explain themselves (but not to the patient) after the event viz:

“A decision not to attempt cardio-pulmonary resuscitation (CPR) like other decisions not to attempt a particular form of medial treatment does not require the patient’s consent. However, as with all clinical decisions, healthcare staff are expected to be able to explain and defend their decisions to their employing authorities and their professional regulatory bodies.”

75. Section 1(1) of the National Health Service Act 2006 (“the 2006 Act”) imposes on the Secretary of State the obligation to “continue the promotion in England of a comprehensive health service designed to secure improvement—(a) in the physical and mental health of the people of England and (b) in the prevention, diagnosis and treatment of physical and mental illness”. Section 1B(1) provides that “in exercising functions in relation to the health service, the Secretary of State must have regard to the NHS Constitution”. The Health and Social Care Act 2012 amended section 1 of the 2006 Act and provided that the Secretary of State must “exercise his or her functions under the Act so as to secure that services are provided in accordance with [that] Act”. The NHS Commissioning Board was established as an independent statutory body on 1 October 2012 with the function of providing a health service through commissioning arrangements with clinical commissioning groups.
76. Further to recommendations from the NHS Future Forum (that advised the Secretary of State on strengthening the NHS Constitution), the NHS Constitution was amended in March 2013 (the amendments are underlined):
- “You have the right to be involved in discussions and decisions about your health and care, including your end of life care, and to be given information to enable you to do this. Where appropriate, this right includes your family and carers.”
77. The Secretary of State’s position is described in some detail in the witness statements of Edward Webb. He is the Deputy Director of the Tissue, Transplantation, Embryology and Consent Branch of the Health Science and Bioethics Division at the Department of Health. The Department of Health is responsible for the NHS in England. There is a Departmental Board chaired by the Secretary of State which forms the strategic and operational leadership of the Department. The NHS is led at a strategic level by a Chief Executive. It is unnecessary to set out the details of the structures of the NHS. At para 19 of his first witness statement, Mr Webb says:

“This is the context in which the Department expects Trusts to have local policies in place, based on expert professional guidance, to ensure that clinicians have the best and most appropriate information available to them. This has been and remains the view of the Secretary of State.”

78. In 1991 the Chief Medical Officer wrote to all hospital consultants reminding them of their responsibility to have a resuscitation policy in place that was understood by all staff who may be involved. The NHS Plan which was published in July 2000 identified the need for patients to be involved in discussions about resuscitation and stated that all NHS organisations would be required to establish and implement local resuscitation policies based on the guidelines of the 1999 version of the Joint Statement.

79. On 5 September 2000 the Secretary of State issued a Health Service Circular entitled “Resuscitation Policy” to all NHS Trusts. Under the heading “Action”, the Circular stated that Chief Executives should ensure that

- “● patients’ rights are central to decision-making on resuscitation;
- the Trust has an agreed resuscitation policy in place which respects patients’ rights;
- the policy is published and readily available to those who may wish to consult it, including patients, families and carers.”

Under the heading “background & other information”, it stated:

“1. Resuscitation decisions are amongst the most sensitive decisions that clinicians, patients and parents may have to make. Patients (and where appropriate their relatives and carers) have as much right to be involved in those decisions as they do other decisions about their care and treatment. As with all decision-making, doctors have a duty to act in accordance with an appropriate and responsible body of professional opinion.

2. In 1991 the Chief Medical Officer of the time wrote to all consultants in England (PL/CMO(91)22) to emphasise their responsibility for ensuring that resuscitation policy was in place and understood by all staff who may be involved, particularly junior medical staff. Chief executives should ensure that consultants are aware of, and fulfil, this responsibility. Recent reports raise serious concerns concerning the current implementation of resuscitation policy.

3. The revised joint statement from the British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing *Decisions Relating to Cardiopulmonary Resuscitation* (1999) [the Joint Statement] is commended as an appropriate basis for a resuscitation policy.

4. Audit of the implementation of resuscitation policy should involve all relevant clinicians, and identify any areas where improvement is required – for example ensuring that decisions made on admission are properly reviewed by the clinical team and that patients and where appropriate relatives, have been properly involved in the process. Clinical audit data should be made available to the Trust medical director and the clinical governance lead, and to the Commission for Health Improvement”.

80. Mr Webb states at para 24 of his first statement that it is the Department’s view that this guidance “is the best means by which to ensure healthcare professionals have the best information available to them”.

81. It is a central aspect of government healthcare policy that, as Mr Webb puts it at para 27 of his statement, “healthcare will be run from the bottom up with decision-making in the hands of the professionals and providers and the power for decision-making given to front-line clinicians and patients”. He explains at para 33 why in his view it is not appropriate to publish national guidance on the issue of DNACPR orders. He says:

“We believe that it is not the existence (or issue) of guidelines (national or otherwise) *per se* that will bring about the best quality decisions in this difficult and sensitive area, but rather the understanding and application of the guidelines. This is not an area in which the Secretary of State would become directly involved.”

82. It is the claimant’s case that, although the Joint Guidance (amended from time to time) has been in place for approximately 20 years, inconsistency and confusion continues to exist. Mr Havers submits that the only effective way of resolving the problems is for the Secretary of State to issue mandatory guidance directed to all doctors who work in the NHS and are concerned with end of life care. He submits that article 8 requires the Secretary of State to issue such guidance and that the court should so declare. He also submits that the Secretary of State obligation is in breach of his statutory obligation to have regard to the NHS Constitution.

83. I cannot accept the submission that the Secretary of State is in breach of section 1B(1) of the 2006 Act in failing to issue a national DNACPR policy. The obligation is to “have regard” to the Constitution. The Constitution does not prescribe the means by which its objective of patient involvement is to be achieved. The decision to commend the Joint Statement was sufficient to discharge the statutory obligation.



84. Nor do I see any reason to hold that the absence of a mandatory national DNACPR policy is a violation of article 8. It is true that the Secretary of State exercises an overarching responsibility for the provision of healthcare under section 1 of the 2006 Act. But to hold that article 8 requires the formulation of a unified policy at national level, rather than having individual policies at local level, is unwarranted and would represent an unjustified intrusion into government healthcare policy. It is government policy to encourage decision-making at local level. That is a political decision which the court should respect unless it can be shown that it is unlawful. If it were a *necessary* consequence of delegating the formulation of resuscitation policies to NHS trusts that the article 8 rights of patients would be systematically violated, there might be a case for holding that the delegation itself was in breach of article 8. But I am not persuaded that breaches of article 8 are a necessary consequence of the Secretary of State's policy. His Circular aims to ensure that patients are "involved in the process" and to that end it commends the Joint Statement as an "appropriate basis for a resuscitation policy". In my judgment, that is an entirely acceptable way of ensuring that the essential requirements of article 8 are met. If there are any ambiguities in the Joint Statement, they should be addressed. As a last resort, if any such ambiguities are causing real problems, they can be resolved by court decision. They are not a reason for holding that the approach adopted by the Secretary of State violates article 8. I should say that I am not persuaded that there are serious ambiguities in the Joint Statement.
85. It would probably be impossible to devise a scheme which is completely free from difficulty. The problems generated by decisions whether or not to impose DNACPR notices are inherently fraught. The question whether to consult and notify the patient is inevitably one of the utmost sensitivity and difficulty. Whether it is appropriate to consult will depend on a difficult judgment to be made by the clinicians. The decision will be difficult and sometimes controversial regardless of whether the DNACPR policy is formulated at a local level or nationally. In other words, I do not consider that the real problem is whether the policy should be imposed from the centre. The Secretary of State has formulated a national policy in part by reference to the Joint Statement. In my judgment, the Circular read in conjunction with the Joint Statement is good enough to meet the procedural requirements of article 8. The Secretary of State would have been entitled to conclude that a central mandatory policy was the right solution. But I do not think that article 8 obliged him to take that course.
86. It is understandable that concern has been expressed about the lack of consistency of approach. *Prima facie*, consistency on important aspects of policy (rather than minor matters) is desirable. If there are inconsistencies (or indeed any other deficiencies) in the involvement of patients in DNACPR decisions, they need to be resolved.
87. The fact that there has been a great deal of debate in this area in recent years has concentrated minds. As I have already stated, the Trust has recently amended its policy, no doubt taking account of the debate and this litigation. On 29 April 2014, it published on-line its UFTO Guidance which was developed "with the aim of improving care for patients and addressing the problems associated with the [DNACPR] order". I have already referred to the leaflet which has been issued by the Trust to all patients since 29 April 2014. No doubt all NHS trusts will take note of

this litigation and take account of the outcome of the appeal and what is said in this judgment. That is a reasonable way for policies to develop. It is not self-evident that a central mandatory policy would necessarily be more effective. The real difficulty facing clinicians in individual cases would remain whichever course was adopted.

### *OVERALL CONCLUSION*

88. I would, therefore, grant a declaration against the Trust that it violated Mrs Tracey's article 8 right to respect for private life in failing to involve her in the process which led to the first notice. I would refuse the other relief claimed against the Trust. I would also refuse the relief claimed against the Secretary of State.

### **Lord Justice Longmore:**

89. I agree with my Lord's judgment. In particular, I agree that Mrs Tracey's Article 8 rights were engaged by the decision to introduce a DNACPR notice onto her notes since it was a decision affecting her private life. I do not, for my part, consider that the common law is any different in relation to a doctor's duty to consult his or her patient in relation to decisions to treat or not to treat, see R (Burke) v GMC [2006] QB 273, paragraphs 50-55 of which do not depend on Article 8 considerations.
90. I further agree, that, as a matter of fact in relation to the first DNACPR notice, Mrs Tracey had expressed sufficiently clearly a wish to be consulted and that in those circumstances Dr Lavinio ought not to have signed a DNACPR notice without consulting her unless (as my Lord says in paragraphs 53-56) he thought that she would be distressed by being consulted and that that might cause her harm.
91. We heard no argument on the question whether the fact that Dr Lavinio's failure to consult Mrs Tracey was a one-off lapse which did not itself engage Article 8. As pointed out in this court's earlier judgment [2014] EWCA Civ 33, in relation to Article 2 of the Convention one-off acts by hospital staff do not necessarily (or even usually) lead to the conclusion that a patient's rights have been violated, see Savage v South Essex NHS Trust [2009] 1 A.C. 681 paras 45, 57-58 and 91 and Rabone v Pennine Care NHS Trust [2012] 2 A.C. 72 paras 19 and 119. Mr Havers submitted, however, that this proposition did not apply to Article 8 and Lord Pannick for the Hospital Trust did not argue to the contrary.
92. I have been somewhat exercised by the well-balanced and powerful intervention by the Resuscitation Council, in which its chairman, Dr Pitcher, has expressed the fear 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 seriously hamper the ability of health care professionals to provide individualised and compassionate care for vulnerable people towards the end of their lives. He makes the further point that in recent years there has been a reduction of inappropriate and unsuccessful attempts at CPR and that a judgment requiring

consultation with the patient save in exceptional cases would be likely to reverse that process.

93. These concerns are entirely understandable and I would hope that the formulation that the clinician has a duty to consult the patient in relation to DNACPR “unless he or she thinks that the patient will be distressed by being consulted and that that distress might cause the patient harm” will go some substantial way to meeting those concerns.

**Lord Justice Ryder:**

94. I agree with both judgments. Mrs Tracey's article 8 rights were engaged by the clinical decision not to attempt to resuscitate her as evidenced by the DNACPR notice that was completed. That decision affected Mrs Tracey's private life and there was a duty on the doctor to consult with her about whether or not to treat. I also agree with my Lord, Longmore LJ, that the duty to consult does not depend only on article 8 considerations, it is also a duty at common law.
95. The duty to consult is integral to the procedural obligation to ensure effective respect for the article 8 right, without which the safeguard may become illusory and the interest may not be reflected in the clinical judgment being exercised. That interest is the autonomy, integrity, dignity and quality of life of the patient. It is accordingly critical to good patient care. The duty to consult is of course part of a clinical process. That process is individual to each patient albeit that it is informed by good clinical practice.
96. The importance of the interest that is to be safeguarded by the duty may sometimes be obscured by the sensitivity of the decision to be made within the clinical process and the stress of the circumstance in which it is made. That is an issue which needs to be identified so that it can be properly considered on the facts of each case i.e. there should be a strategy to deal with discussions and decisions. That is a separate consideration from whether it is clinically inappropriate to enter into discussions about treatment with a patient who does not want to have those discussions. There should be convincing reasons not to involve a patient in treatment discussions and decisions, for example, when the clinician considers that it would likely cause the patient to suffer physical or psychological harm.
97. It is important not to elide the principle that a patient cannot direct a clinician to provide a certain form of treatment although she may refuse it, with the principle that a patient should be involved in her own care. In this case, the Trust published guidelines on 29 April 2014 entitled the ‘Universal Form of Treatment Options (UFTO) Guidelines’ which recognised a distinction between active and passive care informed by the patient’s wishes. There is now an accessible policy which helpfully describes the patient’s right to be consulted before a DNACPR decision is made.

98. In the context of this court's decision, it may be helpful to re-consider the oft repeated GMC guidance that was endorsed by Lord Phillips of Worth Matravers MR in *R (Burke) v General Medical Council* [2006] QB 273 at [50] which can be summarised as follows:
- i) The doctor, exercising his professional clinical judgment, decides what treatment options are clinically indicated;
  - ii) The doctor offers those treatment options to the patient, explaining the risks, benefits and side effects of the same;
  - iii) The patient then decides whether he wishes to accept any of the treatment options and, if so, which one;
  - iv) If the patient chooses one of the options offered, the doctor will provide it;
  - v) If the patient refuses all of the options he may do so for reasons which are irrational or for no reason at all or he may inform the doctor that he wishes to have a form of treatment that the doctor has not offered;
  - vi) If, after discussion with the patient, the doctor decides that the form of treatment requested is not clinically indicated he is not required to provide it although he should offer to arrange a second opinion.
99. That guidance was predicated on the assumption that in the usual case the relationship between doctor and patient usually begins with diagnosis and advice (see [51]). That logically must be right but the guidance tends to render formulaic the need for the patient's involvement at all stages of the clinical process as it develops. The patient is characterised as being primarily responsive to the doctor. The duty to consult which this court has described involves a discussion, where practicable, about the patient's wishes and feelings that is better undertaken at the earliest stages of the clinical relationship so that decisions can be reviewed as circumstances change. That involves an acknowledgement that the duty to consult is integral to the respect for the dignity of the patient.