

## Written evidence from Mrs Mahes Kirby (COV0154)

My submission focuses mainly on a one line note in the [Background Paper: COVID-19](#), namely **Paragraph 6c i: Prioritising certain healthcare for some over others**. The Coronavirus Act was passed without scrutiny of what this represents in practice, namely a multi-pronged approach to deny life-saving NHS treatments to those classed as frail and elderly or disabled.

In response to the COVID-19 pandemic, the Government introduced many restrictions to protect **individuals' right to life**. While the public clapped every week for the front line NHS staff who risked and sacrificed their own lives to save others, NHS leaders were advocating actions verging on passive euthanasia and senicide.

We, like many others reported in the media, only realised this when my husband received a telephone call from our GP on 7 April 2020 to ask whether he would prefer a 4-month or indefinite DNA-CPR (Do not Attempt Cardiopulmonary Resuscitation). I asked if she could write to us explaining why this was needed, attaching relevant information and forms. She refused and told me to search for ReSPECT form UK. Given my objection that due process was not being followed, she did not file a DNA-CPR. It has taken me several months to understand the background to this and its possible breach of human rights.

I am compiling a longer paper on this shameful shadow-side of NHS's history, when its leaders felt that the only way in which some individual's right to life could be upheld was by adopting measures which verge on passive euthanasia. I am playing the Devil's Advocate here since I have no background in Medicine or Law. Not all clinicians were persuaded by their leaders but others did not hesitate to inflict mental anxiety and distress, serious illness and even death on vulnerable patients.

I am grateful to the JCHR for providing us with the opportunity to make some observations, ask some questions and suggest some safeguards. The Coronavirus Act was rushed through without proper Parliamentary scrutiny. My worries do not relate to the BMA guidance but instead to its interpretation and implementation by others who seem to have little regard for patients' lives, let alone their human rights.

### 1. [BMA's "COVID-19 – ethical issues - A guidance note"](#) (link)

The BMA stated *"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 is expected to benefit more from the available treatment" ... "It is only if all facilities and equipment that could reasonably be utilised are at capacity, that resource allocation decisions between individuals would become inescapable."* (p3).

On p5 the BMA proposed the factors which predict survival - a) severity of **acute illness**; b) relevant **co-morbidity**; and c) other factors which reduce the likelihood of survival and recovery, notably **age** and **disability**, translated by NICE to **frailty**. On page 6, the BMA cautions against the mere use of age and disability without reference to clinical factors, and cautioned *"a simple 'cut-off' policy with regard to age or disability would not only be unethical, but also unlawful as it would constitute direct discrimination"*.

Yet, NICE provides an algorithm for intensive care which specifies different methods for assessing the frailty of those over 65 compared to those under 65 ([NICE, 2020](#)). The NICE algorithm is being scrutinised by [Casserley and O'Dempsey \(2020\)](#). Age and frailty (disability) are not predictors of survival these days and should not be the primary determinants for decision-making as they are in the NICE algorithm. They should be the last factors to be taken into account if even that is lawful.

## **2. Interpretation and Implementation of BMA Guidance**

The RCGP urged its members to proactively discuss DNA-CPR ([HSJ, 1 Apr 2020](#)), which might explain the flurry of activity which raised media outcry, prompting the CQC, BIHR and others to caution GPs that their blanket use of DNA-CPR was unlawful. Those who used blanket DNA-CPR did so despite being reminded by BMA that it was unlawful, and ignored the ReSPECT Guidelines issued by RCUK which stress the legal requirements for having discussions with the patients and/or their appointees.

On page 5, the BMA states *“it is important that cardio-pulmonary resuscitation is **not** commenced ... for a patient for whom post-resuscitation intensive care cannot be provided ...”* The RCGP asked GP surgeries ([HSJ, 1 Apr 2020](#)), to ensure that they had a stock of anticipatory medication (opiates usually used at the end of life).

The NHSE Guidance issued over the Easter 2020 weekend included *“Any patient whose advance wishes state they do not wish to receive intravenous therapy or **resuscitation**”* in the list of patients who should not ordinarily be conveyed to hospital unless authorised by a senior colleague ([HSJ, 2020](#)). Was this why GPs were coercing patients to consent to the DNA-CPR so that it could be recorded as their wish? The denial of access to 999 and hospital services seems to be a denial of patients' **human right** to:

- a) Change their mind about DNA-CPR if they still have the capacity to do so.
- b) Have a proper diagnosis. GPs with 10 minute appointments have got things wrong as pointed out to us on several occasions by NHS hospital consultants.
- c) Treatments which do not require intensive care, e.g. clearing a blocked airway, adjusting a pacemaker, giving intravenous antibiotics or home oxygen therapy. If people die as a result of such denial, it could be construed, at least by the public, as passive euthanasia through neglect and abandonment.
- d) A second independent opinion if there is disagreement. I believe this can only be refused if all members of a hospital multidisciplinary team (MDT) agree to the DNA-CPR. If this is correct, it should not be acceptable for a sole GP to override a patient's wishes and file a DNA-CPR for purposes of NHS resource allocation in anticipation of some future lack of capacity when this is clearly contrary to the BMA Guidance.

GPs are so stretched that we have found it difficult to get even a telephone call back to discuss a problem. It is not fair to expect them to play God on life and death issues and make subjective decisions based on multiple heuristics (not predictors) for purposes of resource allocation. Capacity can change very quickly, as it did with provision of largely underused Nightingale Hospitals. The selection of cut-off values for age, frailty and even some morbidities is debatable. It is not surprising that some GP surgeries have not been proactive but have waited until a patient had a medical need to discuss a DNA-CPR. Not only are

As I have pointed out to RCUK, part of the problem lies with the misuse of ReSPECT forms for recording DNA-CPR, without reference to ReSPECT Guidelines, which state:

- a) A patient need not file a DNA-CPR or ReSPECT form. We were told that the only options were DNA-CPR for 4 months or an indefinite period, either in ignorance or in an attempt to mislead.
- b) The ReSPECT form is not a DNA-CPR form and should not be used solely for that purpose. The Guidelines were drafted to enable patients to make their wishes and preferences known in advance should they be unable to express them when needed. Yet, GPs were instructed to use DNA-CPR and ReSPECT forms for resource allocation. In which case, why should it be indefinite and not pandemic and capacity limited? Or, is this going to be the future norm since NHS resources are likely to be stretched in the post-pandemic economy burdened with debt?
- c) The DNA-CPR and ReSPECT forms are not legally binding. Yet, they can deny patients access to NHS emergency services and transport to hospital. So, a DNA-CPR not only denies CPR but also other patient's rights (listed above) despite lacking legal status. Can we have some legal clarity please?
- d) The GPs did not follow ReSPECT Guidelines, since 1) many do not avail themselves of the RCUK training; 2) they knew the ReSPECT process would be a sham since there was no scope for considering patient's wishes for survival over comfort, and 3) they had indemnity under the 2020 Coronavirus Act if they followed professional guidance. But, does this also protect them against unlawful actions arising out of misinterpretation of the BMA's Guidance? Who is liable?

COVID-19 has exposed:

- The different perceptions of the ReSPECT process. It was designed to help clinicians comply with the law by giving patients the opportunity to express their wishes and preferences in advance. Although it is not legally binding, it has been used in an unlawful manner during COVID-19. We need clarity. We must have safeguards in place to prevent abuse, misuse and possible falsification.
- The danger of sole GPs playing God. Captain Tom Moore at nearly 100, walking with a rollator raised over £30 million for the NHS – and NICE is proposing that others with comorbidities who are over 65 and with frailty of 5+ (with walking stick) should be denied NHS life-saving treatments during a pandemic. This is an insult to Captain Moore. We need a panel of senior clinicians whose members can provide an independent opinion on DNA-CPR when there is disagreement.

### **3. Other examples of a disregard for vulnerable lives**

#### ***- Palliative medicine instead of life-saving treatment***

Several US States have won legal damages against drug companies for deceiving clinicians, patients, and the public into thinking that OxyContin is non-addictive and safe ([The Guardian, 2019](#)). My husband was prescribed the same drug marketed as Oxycodone (a Class A drug) for pain from fractures with the reassurance that it was commonly used with no serious side effects. Given the senility symptoms it rapidly induced, I stopped it and an acupuncturist made him pain free in just 2 days. Opioids inhibit breathing. So, why are clinicians who have sworn the Hippocratic Oath prescribing this for COVID-19 which can kill through silent hypoxia (shortage of oxygen)? Also, given reports that home oxygen therapy is a cheap, effective and easy to use treatment for COVID-19, why are shielded people not offered this instead?

I can see a need for palliative care at the end of life; but, why are shielded patients being sent palliative medicines during COVID-19 when they have not had a terminal prognosis and are not infected?

#### ***- Exposing elderly patients to COVID-19 infection***

Vulnerable patients were ordered to isolate and shield for their own and others' protection.

Meanwhile, elderly patients were moved out of hospital without testing into own and care homes incurring unnecessary severe illness and deaths. We now witness a blame game. It is no coincidence that ONS data on deaths in May show an unexplained excess of non-COVID deaths at home and in care homes, while the numbers dying in hospital were down compared with previous years. The elderly died in care homes without the care, succour and protection of their family and friends. It is another indication of the lack of concern for the lives of vulnerable people when emergency actions were taken to protect other individual's right to life.

#### **4. *The Nuremberg Code***

Currently, there are no proven vaccines against COVID-19 and the Nuremberg Code stipulates that voluntary consent is absolutely necessary for "medical experiments" ([Scrutton, Apr 2020](#)). I agree with several others who feel that the right to refuse treatments must stand.

#### **5. *We need to save the economy?***

Already, there is public fear that the elderly and frail are seen as a burden on the tax payer. Cynics would say that the BMA Guidance is an expedient route to saving on pensions, other disability related benefits and social care, and to revenue from death/inheritance taxes, and the release of much needed housing etc for the post-pandemic regeneration. Some vulnerable people need to be allowed to die not just to save the young and fit, but also the economy with an escalating burden of public debt. When the Derbyshire County Council proposed the closure of several of its direct care homes, it claimed that there would be less need for direct care home beds in the future and more demand for independent living. The NHS policy during COVID-19 can make this prediction a reality.

#### **6. *What do I want JCHR do?***

I have provided evidence that DNA-CPR orders are being used to deny vulnerable patients their human rights, leading to avoidable deaths. I hope JCHR will:

- a) Assess whether frail elderly people (not just the extremely vulnerable) are at risk of passive euthanasia. JCHR should ask Public Health authorities to provide data on how many 1) DNA-CPR and ReSPECT forms were filed and 2) how many prescriptions for palliative medicines were dispensed, during April and May 2020. This could shed light on the ONS data which showed an unexplained excess of non-COVID-19 deaths of the elderly in own and care homes.
- b) Insist that DNA-CPR orders filed for purposes of resource allocation during the lockdown should be cancelled now that the pressure on NHS resources has eased. Anticipatory DNA-CPRs seem inappropriate when capacity can change rapidly.
- c) Assess whether the rights of vulnerable patients are breached by :
  - i. The NICE triage algorithm for intensive care which assess those under 65 on an individual basis while those over 65 are assessed on their classification on the Frailty Scale
  - ii. DNA-CPR orders, especially those filed by sole GPs
  - iii. Denial of transport to hospital and consequent denial of other rights as noted above in Section 2, namely the right to change one's mind; the right to a proper diagnosis; the right to life-saving treatments which do not require intensive care, and the right to a second independent opinion on DNA-CPR.
- d) Establish whether it was lawful to enforce DNA-CPR and ReSPECT forms as if they were legally binding

- e) Consider whether patients, who object to sole GPs filing DNA-CPR orders, could seek an independent second opinion from a panel of senior clinicians (set up by CCGs or some appropriate body), especially when the advance decision was made for purposes of resource allocation and not best interests.
  - f) Encourage the RCUK to:
    - Give patients the right to sign the ReSPECT form to confirm that:
      - i. Meaningful discussions have taken place as required by law.
      - ii. They have been shown the form and have given or not given their consent. The absence of a signature should be taken as lack of consent, which is not necessary.
      - iii. That they did or did not request a second opinion and whether this was arranged.
- Given that some GPs have shown disrespect for the RCUK Guidelines, and shown a lack of knowledge of the legal requirements, we need safeguards in place.
- g) Let the patient choose between life-saving treatments, like home oxygen therapy, pain management with acupuncture (if need be, self-funded) and opiates after explaining the potential benefits and harms. JCHR may not be aware that we are often told off by GPs and consultants for reading the leaflets in medicine boxes and the internet, when they try to reassure us that the new symptoms are not due to the medication when they clearly are.
  - h) Support **The Independent Medicines and Medical Devices Safety Review's** recent [recommendations](#), which include:
    - i. Appointing an independent patient safety commissioner to hold the health system to account
    - ii. Transparency of payments made to doctors by pharmaceutical and medical device companies; I am particularly concerned about the overuse of opioid painkillers and antidepressants.
  - i) Ensure that there is no attempt by government to use emergency powers to ignore the Nuremberg code and deny us our right to refuse treatments, including vaccines.

10/07/2020