The Principles of CPR Decision-Making

I want the reader to understand not a set of tick-box rules, but the rather deeper principles involved – because the principles are generally applicable to all situations – so I will begin with a discussion of sailing.

There is a very tricky situation, which a sailing boat can get into. If it finds itself near to a rocky shoreline, with the tide flowing towards the shoreline, and the wind blowing towards the shoreline, the sailing boat will almost inevitably be pushed onto the rocks, often with fatal consequences. Novice sailors ask 'How do you get out of that' and experienced sailors reply 'You don't get out of that position – you avoid getting into that position !'.

It is very difficult to escape from that situation once in it, but even so it can be worse than that. If there were an old-style sea battle in progress, with sailing ships blasting away at each other, and this battle finds itself in that position because tide and wind suddenly shift, you are now being inexorably pushed to your possible doom on the rocks, and also being fired at !

There is only one really good situation for CPR decision-making, and that is the situation of a mentally capable patient, who has had the clinical consequences of a CPA and then attempted resuscitation explained to him, and where the patient has made his wishes about future CPR clearly understood. If a clinician is involved with a patient, and it is known that the patient might have a CPA, then the most important thing to try and achieve, is to keep away from being blown onto those rocks: every effort must be made, to ensure that the patient has explained his wishes about future CPR.

The Most Fundamental Principle

The process in England covering the refusals of treatment while a patient is mentally capable, is usually called Informed Consent, Considered Refusal or Patient Autonomy. The principle is that only the patient can judge how acceptable the clinical outcome of an offered treatment will be in the context of his own wider-life situation. The role of the clinicians is to inform the patient of clinical outcomes, and to competently provide any treatment which is offered and accepted. The patient alone, decides whether to accept any offered treatment, and he need not give his reasons for accepting or refusing: he decides whether to explain any background.

If a patient has a CPA, he inevitably becomes mentally incapable, so he must both consider and also express his wishes regarding CPR before the CPA occurs. It is logically ridiculous, to suggest that 'because he had the CPA, he might have changed his mind' – if that argument were valid, then no patient's refusal of future CPR could ever be unchallenged. So it is important to understand that if a patient is mentally capable until a CPA occurs, then although technically he is mentally incapable during the CPA, logically you can treat the situation as if the patient were still capable. If a patient has discussed future CPR at 8pm, refused it and you are certain he understood the clinical consequences of attempted CPR but preferred to be left in peace to die if he had a CPA, then if he has not told you that he has changed his mind before 9pm, and he arrests at 9pm, you should not attempt CPR.

Decision Making

There is a fairly recent, and therefore still being tested in the courts, law called the Mental Capacity Act, which sets the legal rules for the medical treatment of, and also wider decisions concerning, persons who lack mental capacity. It is difficult to create the wording for such a law, but it is very clear from the wording of this law, that its basic intention was to somehow try and extend the principles which govern the treatment of patients while they can speak for themselves, into periods when they are unable to do that because of mental incapacity. So the law essentially requires a clinician at a CPA to ask himself this question, unless the clinician is aware that the decision rests in the hands of another person who has already made it (see on), as the starting point of any decision making process:

‘Am I reasonably certain, of what this patient would say to me, if I could ask him if he wanted to be treated (and he understood the outcome of the offered treatment) and he could give me his answer ?’

If a clinician can answer to himself ‘Yes I am – I am reasonably convinced that he would have refused the treatment’ then the clinician should incur no legal liability for withholding the treatment, but might incur liability for attempting the treatment.

If a clinician can answer to himself ‘Yes I am – I am reasonably convinced that he would have requested the treatment’ then the clinician must proceed from that answer, to the somewhat more complicated decisions which stem from it.

For CPR, it is almost always correct that if it is known that attempted CPR would fail for a clinical reason, then CPR should not be attempted (it is possible to have a situation where the CPR attempt would benefit not the patient but a different person – this would be a very rare situation, but possible): otherwise, if CPR might be successful clinically, CPR should be attempted unless one of these things applies (this is the ranking order):

* You clearly understand that the patient has recently considered the question of future CPR while he was mentally capable, and that the patient has told those persons closely involved with him or his care that he refuses it (this refusal can be for any clinical cause of a CPA, or with qualifications to the refusal: the qualifications need not only involve clinical factors);

* The patient has written an Advance Decision which is signed and witnessed, but the Advance Decision has not yet been discussed with those caring for him or closely involved with him, to cover the situation when he would be unable to discuss his wishes directly with those closely concerned with his care, and it appears to refuse CPR for the CPA you are considering;

* A single Welfare Attorney whose powers extend over CPR decisions, or all Welfare Attorneys in agreement if there are more than one, has issued an instruction that CPR should not be attempted in the situation being considered;

* A Court deputy has issued an instruction that CPR should not be attempted in the situation being considered;

The situation then becomes somewhat fragmented, because if you have been ‘talking to the patient’ you should understand the patient’s wishes, but if you are only ‘loosely or temporarily involved’ – for example if you are a stand-in district nurse, or a paramedic called to a CPA – you might reasonably anticipate being present at a CPA, but you cannot understand the situation in the way that a GP, a relative who lives with the patient, or the lead district nurse should be able to. The interpretation of the law, ethics and morals, becomes intricate in this situation. Writing guidance for the benefit of those who have not thought deeply about the complexities of that interpretation, is even more difficult.

The problem, is that if it is not agreed that the patient has clearly expressed his wishes about CPR, and that everyone else is in essence just following those wishes, somehow it is necessary to ‘work out what the patient would have said’. Imagine that a wife was involved in a car crash, is injured and comatose, and you are trying to work out if she would refuse CPR if a CPA occurred. The only way to do this, is for those clinicians who understand the clinical prognosis without a CPA occurring, and also if a CPA occurred and CPR were attempted, to describe those clinical factors to those non-clinicians who have enough ‘life experience of the wife’ in order to ‘decide if I can suggest, what she herself would have said if asked’. This is much harder, than simply listening to a patient who is ill but capable, when he tells you he is refusing future CPR. And it gets very complex, when the situation involves an incapable parent (the patient) and two daughters, and no other people who know the patient really well. If the two daughters honestly come up with different answers – one says ‘I’m sure mum would want CPR’ and the other says ‘I’m sure she would refuse CPR’ – then it appears that all clinicians must be in support of CPR, one daughter must be in support of CPR, but the other daughter must try to prevent CPR: and everybody, appears to be legally correct, until a court

ruling has been sought and given. It is far from clear, that the complexity of such situations has yet been tested in court – so great caution, about claiming who is right and wrong, is called for.

Ignoring that problem of people not agreeing, the rest of the chain works like this.

* If you are a person who has been closely involved with the patient, and you have been involved in enough discussions about the patient's medical situation and his likely wishes for CPR, then if you are present when he arrests, you are obliged to try to make a best interests decision in the situation you are faced with: you have a legal defence against liability, if you can reasonably argue that 'I did everything I could to ensure that I was reasonably able to make a best interests decision, and I did my honest best to then obey the MCA'.

* If you are present at a CPA, you were not 'closely involved with the patient before the CPA', and can claim that 'nobody had done anything to persuade me that another decision would be correct', then you should attempt CPR unless its outcome would appear to be clinically futile.

* If you are a paramedic, or any other health professional not 'closely involved with the patient' and you have been told that the patient is already in the End of Life Care chain, or that he has written an Advance Decision refusing CPR, or you are aware of a DNACPR order, then you are in a different position from everyone who should properly understand the interpretation of an Advance Decision, or the reasons behind a DNACPR order. Basically, you are in the position of being guided towards a correct decision, rather than being able to properly consider the best decision. This makes it very complex for paramedics – I am not going to discuss that complexity in detail, but I would ask the reader to think about this. If a relative calls 999 and tells the attending paramedics 'My dad explained to me last night that he no longer wanted any resuscitation attempts, because he is suffering too much, but we were going to explain this to his GP when she visits this afternoon – he has stopped breathing, I know he wanted me to just let him die in peace, but I've called you to check' and there was not a clinical DNACPR in place, would you be rather upset if the paramedics then attempted CPR, if you were the relative ? If the father woke up in hospital, damaged by a severe stroke, and then 'lingered in a miserable condition for a few weeks or so' before he died, if you were the father wouldn't you be angry because you had explained you had not wanted CPR to be attempted ?

I am not even going to attempt to analyse the complexity of CPR decision making if the patient was not able to make his own decisions: such as when minors, or long-term mentally incapable persons are involved. If you are involved with that type of situation, you need to have very specialist expertise, and must do your own homework.

And without proving why it is correct, which makes this so lengthy that people will either not read it or tend to become confused, I will explain on the next page the decision-making hierarchy which the law leads to, and also some of the things which would logically make it less likely that everyone will be 'forced onto the rocks': my closing words, here, are that if you want to turn 'the tide and wind is against us' into 'and we are also being fired at' then a very quick way of starting a war is to say, or imply, 'we care about your mum, more than you do' or 'you can't prove that is the truth, so we are assuming you are lying to us'.

Professionals should always attempt to 'also put myself in the other person's position, before I decide if his actions were reasonable', and professionals should be aware that the amateurs will assume 'these people are trained, understand these things and know what should happen' **but as seen from the position of a wife, son, etc**. If, from that non-professional perspective, the behaviour of professionals looks stupid, or immoral, then very quickly the amateurs conclude 'I seem to have got all of the idiots, today !' and that does not help things, at all !

The DNACPR Justification Hierarchy

1 A face-to-face discussion with a mentally capable patient, which takes place during the clinical events which lead to his CPA, the outcome of which is that the patient issues a DNACPR Instruction which those who were involved in the discussion can interpret correctly

2 An apparently valid and applicable Advance Decision refusing CPR which has not been discussed with the patient

3 A DNACPR decision made and communicated by either a single welfare Attorney (where only one has been appointed), or agreed and communicated by all Welfare Attorneys

4 A DNACPR decision made and communicated by a Court Deputy

5 A DNACPR decision made by a person who is sufficiently informed of the patient's clinical situation and likely wishes, to enable that person to defensibly consider section 4 of the MCA.

6 A DNACPR action, which is based upon information supporting the reasonable belief that something within categories 1 to 5 makes DNACPR the best available behaviour.

7 If none of the above apply, but it is clear that attempted CPR would be clinically futile, then DNACPR

8 If none of 1 to 7 apply, CPR should be attempted

Helpful and Unhelpful Behaviour

These things are generally true, but especially so if a patient is being cared for within his own home, in an End of Life Care situation. In that situation, patient, GP, nurses and relatives can all talk to each other at different times and places, while others in the group are not present, and it is extremely difficult to ensure that at any particular time, everyone involved knows everything they should ideally know. And recorded, and especially disseminated, information can often be out-of-date. This can become extremely confused, overall.

* Promote open communication between everyone who is closely involved with the patient, and also between that group of people and the patient – do not do things which prevent communication, or make anyone think they are being told less than they need to know, or are being deliberately deceived.

* Do not expect to know everything – it is highly unlikely that anyone will be in the position of knowing everything which might be relevant.

* Do not confuse CPR decision making, with verification of death protocols – these are two different sets of rules, which happen to tend towards convergence when a patient's death is clinically inevitable. But they are conceptually quite different, and it is a case of applying the rules for CPR decision making first, and then post-mortem moving on to verification protocols. It is wrong, and possibly illegal, to allow CPR decisions, to be influenced by verification of death procedures.

* Remember that bereaved relatives are covered by the Human Rights Act, and are particularly susceptible to the accumulation of psychological damage in the immediate hours following the death of someone they loved – otherwise, why would people 'go into shock' when a death occurs ?

* If you are confused by someone's behaviour, do not make assumptions about the reasons for it – ask the person, explaining that you are confused by what is going on. Only by asking and answering each other's questions, does a group of disparate people get anywhere close to something approaching a common understanding.