Best-Interests Decision-Making when only ‘emergency clinicians’ and family carers are present: who should decide what, who should contribute what?

My starting point, is that the MCA has moved away from ‘the doctor makes the decisions’ and very clearly to ‘informed patients make their own decisions’. This emphasis on the application of what I shall call ‘the patient’s individuality’ to the decision-making, also applies [but with added complexity] to best-interests decision-making when the patient is mentally incapable (which for the purposes of this piece means ‘was capacitous until a cardiopulmonary arrest left the patient unconscious’). I would point the reader at:

http://www.bmj.com/content/357/bmj.j2224/rr-8

And also at:

http://www.bmj.com/content/352/bmj.i222/rr-0

The ‘Principles’

1) Best-interests decision-making requires two different ‘inputs’: the clinical prognoses (the outcomes with and without treatment) and also an understanding of which clinical outcome the patient ‘would have chosen’.

2) You can only hear a patient’s expressed decision, if you are present to listen to it: you can only glean an understanding of the vaguer concept of ‘patient preferences’ by spending time with the patient (put at its simplest ‘by knowing the patient as an individual’)

3) Family carers and healthcare professionals should be working together - not fighting each other.

The way a mentally-capable reaches a decision [to consent to or refuse an offered medical intervention] is by ‘applying his particular way of thinking’ to the information about the clinical factors **which has been provided** by his clinicians.

The people who ‘understand the patient’s particular way of thinking’ after the patient has lost capacity, are ‘those close to the patient’: logically we would arrive at ‘those close to the patient work out best-interests **after they have been provided with** clinical information’.

Scenario: a single family carer calls 999 and the patient turns out to be in CPA

Suppose a single family carer has called 999. Only the family carer is present to input ‘any understanding of section 4(6) of the MCA’ - the ‘understanding the patient as an individual aspect’ - and **there is not the time** to ‘involve others’ during a CPA. If the sole family carer present tells a 999 paramedic ‘if he is arrest {and it is definitely the paramedic’s role to decide if the patient is in CPA} then I feel sure you should not attempt CPR’, then in my view the paramedic should not attempt CPR: doing otherwise ‘questions the integrity of the family carer’.

Scenario: 2 or more family carer call 999 and the patient turns out to be in CPA

Suppose 2 or more family carers have called 999. Only the family carers are present to input ‘any understanding of section 4(6) of the MCA’ - the ‘understanding the patient as an individual aspect’ - and **there is not the time** to ‘involve others’ during a CPA. If every family carer present tells a 999 paramedic ‘if he is arrest {and it is definitely the paramedic’s role to decide if the patient is in CPA} then I feel sure you should not attempt CPR’, then in my view the paramedic should not attempt CPR: doing otherwise ‘questions the integrity of the family carers’.

Footnote: if there are 3 family carers, and two say ‘I’m sure you shouldn’t be attempting CPR’, while the third ‘doesn’t know’, then this is still ‘the paramedic should not attempt CPR’.

Scenario: 2 or more family carer call 999 and the patient turns out to be in CPA

Suppose 2 or more family carers have called 999. Only the family carers are present to input ‘any understanding of section 4(6) of the MCA’ - the ‘understanding the patient as an individual aspect’ - and **there is not the time** to ‘involve others’ during a CPA. If even one of the family carers present tells a 999 paramedic ‘if he is arrest {and it is definitely the paramedic’s role to decide if the patient is in CPA} then **I feel sure you should attempt** CPR’, then in my view the paramedic should attempt CPR: the reasoning is that there is no way the paramedic can decide whose best-interests decision ‘is better’, and in this situation the paramedic must default to ‘attempting to preserve life’.

Footnote: **This does not mean that any of the family carers are ‘wrong’ - those who are convinced the correct decision is to attempt CPR, and those who are convinced the correct decision is to not attempt CPR, are equally right: the assumption must be that they have considered section 4 of the MCA but have arrived at different conclusions for what is in the patient’s best-interests.**

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

A face-to-face elaboration of a CPR refusal, directly from the patient, gives the person to whom the refusal is made the best possible understanding of the patient’s DNACPR instruction (see also note 1).

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

If an Advance Decision has been written but not discussed, it must be taken at its face value.

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

(Note: for non life-sustaining treatments, a Court Deputy can fit here between 3 and 4 - see section 20(5) of the Act))

These 2 things are ‘true section 4 best interests decisions’ , and the Welfare Attorney ranks highest because the WA was appointed by the patient to make the decision; then any person who has been sufficiently involved with the patient, to justify making a section 4 best interests decision (see note 2).

4 A DNACPR decision made by any 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.

This is the situation of someone such as a paramedic, who if called to an arrest cannot have the necessary background and time to genuinely consider a section 4 best interests decision.

5 ADNACPR action, which is based upon information supporting the reasonable belief that something within categories 1 to 4 makes DNACPR the best available behaviour

This is not a section 4 best interests decision (see note 3).

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

If a patient is known to be within the End-of-Life Care ‘system’, then it appears negligent if this default behaviour is resorted to.

7 If none of 1 to 6 apply, CPR should be attempted

Note 1
This is not, apparently, a ‘genuine’ section 4 best interests decision. The reason, is that in this situation there is no plausible reason to doubt the patient’s decision - it is the most clearly-understood of all possible refusals from a patient. It isn’t relevant if there is a written ADRT, because if the patient is mentally capable until a CPA occurs, his explanation of the meaning of the ADRT defines its meaning: the patient’s explanation of what his ADRT means, is superior to anybody else’s interpretation of its meaning.

Note 2
A genuine section 4 best interests decision, involves ‘working out the patient’s likely wishes’ - there must be some degree of uncertainty about those wishes (a degree of uncertainty entirely absent for 1). Whoever is considering the best interests test, the fundamental struggle is in persuading oneself that this uncertainty is small enough, to believe that the patient would have refused CPR for the particular CPA in question.

Note 3
If CPR would be clinically futile, it will not normally be offered - this is a ‘clinical DNACPR’ and it is not a section 4 best interests decision, because it is not dependent on the patient’s wishes (and section 4(6) of the best interests test, stresses the importance of discovering the patient’s likely wishes).

Behaviour should be co-operative with the objective of arriving at the best-achievable decision and the enacting of that decision!

The first question a person should ask is ‘can I defensibly make a section-4 MCA best-interests decision ?

The answer is either yes, or it is ‘no - I don’t myself understand enough about this patient’s ‘individuality’.

If it is no then such a person should ask ‘is there someone else who could make a better decision than I could ?’ and if the answer is ‘probably’ then helping that person by providing information should be your role.