Standing between a 999 Paramedic and a person who is in cardiopulmonary arrest: the likely consequences

Dr Mark Taubert recently pointed to a piece in the New York Post about cardiopulmonary resuscitation (CPR) in his tweet at:

https://twitter.com/DrMarkTaubert/status/980009992119046145

A few Tweeters started to discuss CPR: those of us involved in the discussion were not impressed by the NYP article (most of us didn't like it, at all, is probably a fair description of the comments), and the discussion broadened out into other issues around CPR.

One of the things that cropped up, was the problems facing a person who is relatively healthy, but who wants to forbid attempted CPR for a 'sudden cardiopulmonary arrest' which happens while the person is in his or her own home. Someone who wants to do that, tweeted a real Advance Decision (ADRT) which is intended to prevent any attempts at life-sustaining treatments: the tweeted ADRT includes

If I lack capacity to give (or withhold) my consent to medical treatments then I REFUSE all medical intervention aimed at prolonging or sustaining my life.

This is someone in real life, trying to do what Alan wants to do in my own hypothetical 'Alan and Liz' scenario – you can find 'Alan and Liz' on page 38 of my piece 'Mike's Little Book of Thoughts about End-of-Life v2' which can be downloaded from:

https://www.dignityincare.org.uk/Discuss-and-debate/download/317/

As is usual on Twitter, 'threads fragment' so finding tweets you've seen isn't always easy, nor is keeping track of exactly 'what conversation is going on' – but, I was discussing with the person who has that ADRT, whether it would successfully prevent 999 paramedics from attempting CPR. We both think the answer is much closer to the 'no or probably not' end, than to the 'it would stop the paramedics from attempting CPR' end (we seem to agree that the ADRT would stand much more chance of preventing CPR inside a hospital – and that a judge would accept the ADRT [but, I would point out that judges rarely attempt CPR, so I wouldn't be writing an ADRT refusing CPR with the intention that it should stop a judge from attempting CPR – my objective would be that my ADRT should stop 999 paramedics from attempting CPR]).

Me:

And I think your ADRT would 'work' in front of a judge, and probably inside a hospital - I'm far from convinced that if you arrested at home, it would stop 999 paramedics from attempting [and certainly 'starting'] CPR.

Reply:

Agree. That's exactly why I have a DNACPR too.

I am not going to discuss 'a DNACPR too' here, beyond pointing out that It would be a very peculiar DNACPR (and for clarity: a 'DNACPR' is a form signed by a doctor, unlike an ADRT refusing CPR which is signed by the patient) because it could only really say two things – 'I am aware that my patient **had** an ADRT refusing CPR **when I last spoke to her**, but **I don't know if she has retracted her ADRT since we spoke**, and her ADRT refuses CPR in a situation when **I would not be able to certify** her death'.

I can't really see, how that DNACPR 'is logically helpful'. I see it as potentially unhelpful – I want clinicians to respect ADRTs, instead of always 'looking for things signed by the doctor'.

Of more interest – and the reason I wrote this piece – was the following tweet to the previous one I've shown. I'll join the two together, here:

Agree. That's exactly why I have a DNACPR too. And have appointed my wife as LPA(health) and she is willing to interpose her body between mine and the paramedic. Doing everything I can!

LPA(health) is the tweeter's term for a person I usually describe as a Welfare Attorney – a person appointed under the LPA, to make best-interests decisions about treatment, if the patient can no longer do that.

This gives me the chance to give my opinion about 'what would happen, if a welfare attorney stood between the patient and the paramedic'. This is my opinion, based on my experiences after my mother's death at home in 2008, and on my impression that not a lot has changed since then. What happened after my mum died at home in 2008, is described in my piece at:

https://www.dignityincare.org.uk/Discuss-and-debate/download/315/

I am going to assume, for the rest of this discussion, that a husband has written an ADRT forbidding CPR if he arrests for any reason at all, that his wife is his Welfare Attorney and that she has been given decision-making authority over all treatments by her husband (and that the ADRT was written after the wife's appointment: technically it then removes the wife's decision-making authority, if the ADRT is applicable at the time of an arrest – I think if the ADRT is not considered to be applicable in the circumstances of the arrest, the wife would then still possess decision-making authority over the necessary best-interests decision about CPR).

Point 1: the wife probably does need to call 999, to be sure that her husband is indeed in cardiopulmonary arrest (CPA).

So, we will assume that 999 paramedics (or a single paramedic) arrive, and we will assume the person is in CPA. Suppose that the wife produces the ADRT and the paramedics say 'doesn't apply in this situation – my guidance says I have to attempt CPR'. So, the wife says 'if you think the ADRT doesn't apply, then I'm an attorney under the LPA and my authority extends over CPR – and I'm telling you, I've decided that CPR is not in my husband's best interests' - and, again, the paramedics say 'it isn't your decision, in this situation'.

At this point, I need to somehow get the wife between the paramedics and the husband who wrote the ADRT to prevent attempted CPR: easiest if I assume just one paramedic, who had to leave the husband in order to get a bit of kit – and returns to find the wife blocking access to 'the patient'.

Comment: whatever happens from here on in, I'm fairly sure that the wife will come out of this 'mentally damaged' (it is hard enough if a loved-one suddenly collapses, and you think your loved-one is dying, **without also** 'having to fight with the 999 Services and then being interrogated for hours) ***- if she does what I suggest she does here, the police and paramedic <u>will also</u> 'come out 'damaged'' which might make them think.*** If my position here seems unreasonable – well, I'm sorry, but I've been discussing this issue for years, and in my view unless the behaviour of 999 is challenged in a way which 'shares some of the pain with them', they are not likely [or at least, less likely] to alter their behaviour.

I'll assume that the wife manages to prevent the paramedic from attempting CPR, and it would be inevitable, I think, that the paramedic would involve the police. So, I'll now go through what I suspect would happen, by way of conversation: and I am putting into the wife's mouth, what I myself would say in this situation.

Police to Wife: Why did you prevent the paramedic from attempting CPR, after you had called the paramedic out?

Wife to Police: Because I'm her attorney with decision-making authority over CPR – and despite my telling the paramedic to not attempt CPR, it was clear the paramedic was going to attempt CPR.

Police to Wife: So why did you call the paramedic?

Wife to Police: Because I needed to know what the clinical situation was – I'm not a clinician.

Police to Wife: You've admitted you aren't a clinician – why do you think it was your decision to make, not the paramedic's?

Wife to Police: Because the law says it was my decision to make.

Probably a quick conversation between Police and Paramedic at this point, and Police would probably return with:

Police to Wife: The paramedic tells me it was his decision, not yours.

Wife to Police: I'm not responsible for the Paramedic's understanding of the law – but if the Paramedic had attempted CPR, we would currently be discussing my suggestion to you that the Paramedic should be arrested for assault.

Possibly another conversation between the Police and the Paramedic – then:

Police to Wife: The Paramedic says you couldn't accuse him of assault.

Wife to Police: He hasn't applied to a court for a ruling about my expressed decision – that leaves him with no legal defence against a charge of assault, when I read MCA 6(7), had he attempted CPR after I had said it would have been against my husband's best interests.

Prediction: Police and Paramedic, would be getting ‘somewhat vexed’ by now – they might also be wondering if they had ‘got the law right’ or not (I was told by a police officer who was on the beat a couple of years ago, that ‘if we needed to understand the MCA, we would Google it’).

The scenario could get very complicated, and develop in various different ways from this point – so I will not add any more, beyond hypothetical questions, and my suggested answers.

Police to Wife: You stopped the paramedic from trying to keep your husband alive, so why did you want him to die?’.

Answer: How dare you suggest that ‘I wanted my husband to die’ - I will be formally complaining about you saying that to me, what is the name of your Chief Constable?

Police to Wife: How did you know, that withholding CPR was in your husband’s best interests?

Answer: You cannot legally ask me that – what you are allowed to ask me, is how I complied with MCA 4(9). In other words, you can ask me what I had done to justify my making of the best-interests decision I made.

Police: So – why were you justified in making the decision you made?

Answer: Because I had discussed CPR with my husband.

Police: What did he tell you, in those discussions?

Answer: I don’t need to tell you that – the conversations were to inform my decision-making, and they have nothing to do with you.

Police: You said I could ask – now you are refusing to answer.

Answer: I have answered – you are confusing the content of the conversations between my husband and me, with the issue of whether or not the conversations happened: the content isn't something you can ask me to disclose – and I cannot see why you would need to know anyway – because it is my having had the conversations, which satisfies the duty imposed on me by section 4 of the Mental Capacity Act.

The point of this piece: **whatever the wife does** – calls 999 and lets the paramedics attempt CPR, doesn't call 999 until after her husband is definitely dead assuming he was in CPA (or – an absolute nightmare – waits for 30 minutes, realises that her husband wasn't in arrest, then involves 999 and subsequently sees her husband 'living on with potentially-avoidable clinical damage' which prompter intervention might have reduced'), calls 999 and 'obstructs the paramedics if they try to attempt CPR' - **it comes out badly for the wife!**

That is deeply wrong – the wife, would be doing what her husband wanted her to do: and 'the husband was capacitous before the arrest – so the husband decides what should happen' is the fundamental concept within our law.

This hinges on 'the professionals do not default to trusting relatives and family carers' in situations when 'the relative was there, and is logically the only person who could know' - **it really winds me up!**

See also, in my PDF from:

https://www.dignityincare.org.uk/Discuss-and-debate/download/317/

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if the professionals 'consult the public' but the professionals then withdraw into a room and 'haggle among themselves over policy or protocol', you inevitably seem to end up with, to at least an extent, what I have described as 'the professionals huddling together under the umbrella, and the laymen being pushed out into the rain'.

Put another way, if only the professionals are sitting around the table when the protocol is being argued over, the 'balance points' will almost certainly be different from where they would be if the laymen were also sitting around that table: see for an example, the piece at the top of page 5 about whether or not a written Advance Decision should have its 'authenticity' checked during 'an emergency'. Nobody can say where those 'balance points' between competing objectives should be – but, it can be reasoned that they will depend on 'how many groups with competing interests are around the table'.

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WHAT CAN BE KNOWN ?

Things which have happened, might be 'knowable'. But even some of these, are not 'knowable' 'universally'. If two people talk together, then one becomes unconscious before any record or dissemination of the conversation has been made, the only person who 'knows' about the conversation is the remaining conscious participant.

Records of past events, can exist and be read, but how does a reader 'know' the record is accurate ?

Things like 'the meaning of a multi-party discussion' can be disputed after the event by the participants: if there is a dispute about 'what the words meant', does anybody know what the words meant ?

Some present things, can also be 'unknowable' - in my end-of-life debates, police officers clearly 'want to know why a deceased person died', but often that simply isn't 'knowable' at the time.

Future events, are typically significantly 'unknowable'. Things such as the outcome of a cardiopulmonary resuscitation attempt, are so vague, that the term 'unknowable' fits them well. If you are aged 80, then the answer to 'will I be alive in 5 years time ?' isn't quite the same as if you are a healthy 20 yr old, and you ask yourself the same question.

There is also a problem, in that 'you can only know about, what you can see', where I'm using 'know' more in the sense of 'properly understand'. And people are 'perspective blind' to quite a lot, of 'what is in front of them'.

Why does any of this matter ?

In terms of my own 'stuff', mainly because the guidance currently being published, downplays 'uncertainty', and as a consequence would lead 'inexpert professionals' to fail to understand how complicated the real-world situations which other professionals are involved in, really are. For example, police officers are not routinely involved in end-of-life at home, but are involved sometimes: the 'theoretical situations and behaviour implied by current EoL guidance' which might be read by a [diligent] police officer, are nothing like as complicated as the real-world interactions between patients, GP, family and nurses.

I have recently sent an e-mail to several doctors who were involved in a Royal College of Physicians podcast about end-of-life (and also to Mark Taubert), and I attached two PDFs to my e-mail. One is the piece describing what happened when

my own mother died, and the URL for that was given earlier. The other piece is my comments on the podcast, and you can download it from:

https://www.dignityincare.org.uk/Discuss-and-debate/download/314/

I asked a question, in that piece:

My recent tweet at:

https://twitter.com/MikeStone2_EoL/status/974955854448480256

elicited a response from Jim Crawford, an A&E consultant:

Ethically (and I hope legally) if a patient with capacity has expressed that wish to anyone, and that wish is known to the people caring for the patient at the time of cardiac arrest, then starting CPR would be wrong, without having a very, very strong reason for doing so.

It seems crystal clear to me – but apparently not to ReSPECT, **so I would like to know if you (Bee, Jane, Amy and Mark) also see this as 'crystal clear'** – that a refusal of a [future] treatment which has been clearly expressed to a person, is 'legally binding on' that person, irrespective of whether the person is a clinician or a family carer?

As Mr Justice MacDonald explained (see the start of my piece about ACP at

https://www.dignityincare.org.uk/Discuss-and-debate/download/293/)

C is entitled to make her own decision on that question based on the things that are important to her, in keeping with her own personality and system of values and without conforming to society's expectation of what constitutes the 'normal' decision in this situation (if such a thing exists). As a capacitous individual C is, in respect of her own body and mind, sovereign.