Various groupings of people at a cardiopulmonary arrest: an analysis of 'is there a decision-maker for CPR?'

I decided to write this, after Dr Kathryn Mannix said on Twitter that it is necessary to identify which individual will make any particular best-interests decision. Professionals often make that assertion - it is, as it happens, not something which is possible, if you read the Mental Capacity Act.

I could have pointed to my 'Anne, David and Dr Jones' scenario - which investigates the same legal question - but instead I decided to tweet about, and to subsequently write about here, a different scenario involving CPR.

Some 'proofs' are in italics in this piece - you can simply read the normal text, and skip the bits in italics, if you wish to. To examine the MCA, I progressively add extra people to the scenario, and I have numbered the variations 1, 2, 3 etc.

1) A GP and a husband are in the home, and they are discussing whether CPR should be attempted if the wife, who for the purposes of this decision they both agree is not capacitous, should have a cardiopulmonary arrest. They do not agree: the GP believes that it would not be in the wife's best interests for CPR to be attempted, and the husband believes that it would be in his wife's best interests for CPR to be attempted. The husband has also been taught CPR as first aid.

Suppose the wife arrests. There is absolutely nothing in the MCA itself (in the Act) to suggest that the GP can stop the husband from attempting CPR: and, if their respective decisions were reversed, there is nothing in the Act to suggest that the husband could stop the GP from attempting CPR.

*The husband and the GP, **because they are already involved in the care of a mentally-incapable person**, are required to apply MCA section 4 to their decision-making: if they can both claim to have satisfied MCA 4(9) then both of their decisions, despite being in conflict, are legally-defensible.*

4(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.

2) We now add one of the nurses who works for the GP, a practice nurse, to the mix: so we have the husband, the GP and the practice nurse present when the wife arrests.

Now, we have a layman and two clinicians present: it is now probably the case, that if the GP tells the nurse that CPR should not be attempted, then the nurse should not attempt CPR. I say 'probably' because that stems from what I recently described as 'a weird 'pseudo-legal' authority - an 'authority' which the GP could possess, because of section 42 of the MCA.

It 'goes' like this, starting with MCA section 42:

42(1) The Lord Chancellor must prepare and issue one or more codes of practice—

(b) for the guidance of persons acting in connection with the care or treatment of another person (see section 5),

42(4) It is the duty of a person to have regard to any relevant code if he is acting in relation to a person who lacks capacity and is doing so in one or more of the following ways—

(e) in a professional capacity,
(f) for remuneration.

Then, the Code of Practice to the MCA develops the idea, such as in:

5.31 All reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death. The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. ***Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment****.*

I will leave it to the reader, to figure out exactly what 'professional guidance' means: the BMA, RCN and RC(UK) jointly publish a piece of guidance about CPR decision-making, and the GMC publishes quite a lot of guidance for doctors, while the NMC seems to publish rather less guidance about such matters for nurses. The GMC and the NMC are regulatory bodies for the professions (they register and can strike off doctors and nurses), the BMA describes itself as effectively a 'trade union' for doctors, the RCN is a combination of 'trade union' and 'professional college' for nurses, and I'm not sure what the RC(UK) should be described as.

3) Now add a 999 paramedic to the mix: so we now have the husband, the GP, a practice nurse and a 999 paramedic present when the wife arrests.

It is possible that the GP can 'order' the 999 paramedic to not attempt CPR, but it isn't obvious to me where that has been established: presumably it needs guidance written by the College of Paramedics, which says 'you must obey decisions made by doctors' but as the guidance for paramedics is hard to get your hands on, I don't know what the guidance for 999 paramedics currently states.

But, it seems clear that the 999 paramedic **cannot sensibly claim** to be able to make MCA best-interests decisions: you can either consider MCA 4(6), or for example the October 2007 version of the BMA/RCN/RC(UK) Joint CPR Guidance

(called officially 'Decisions relating to cardiopulmonary resuscitation: A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing) which **correctly explains** on its page 12:

Great care must be taken when people other than the patient make or guide decisions that involve an element of quality-of-life assessment, because there is a risk that health professionals or those close to the patient may see things from their own perspective and allow their own views and wishes to influence their decision, rather than those of the patient. These considerations should always be undertaken from the patient's perspective. The important factor is whether the patient would find the level of expected recovery acceptable, taking into account the invasiveness of CPR and its low likelihood of success, not whether it would be acceptable to the healthcare team or to those close to the patient, nor what they would want if they were in the patient's position.

I consider that certain parts of the 2007 version (and indeed of subsequent revised versions) of the Joint CPR Guidance are somewhere between 'misleading and ambiguous' and 'downright legally wrong', but the section above is spot-on: **it also invites the question 'who better understands 'the patient's perspective' - those close to the patient [a term which means the patient's close family and close friends] or the health professionals?'.**

4) Now add a the wife's sister to the mix: so we now have the husband, the GP, a practice nurse, a 999 paramedic and the wife's sister present when the wife arrests.

Adding the wife's sister - another 'relative or family-carer' - to the mix, doesn't change anything: we still only have:

a) if individuals believe they made their own decision in satisfaction of MCA 4(9), then the individual's decision about CPR is legally defensible;

b) the senior professional can **probably** control the decision-making within the group of professionals who are present, but the husband, wife's sister and GP cannot control each other's decision-making;

c) a logical conclusion, which to my knowledge has not yet been considered by a court, that the husband, GP and wife's sister are probably the only people present who understand enough to make 'genuine' best-interests decisions.

5) Now add the wife's brother to the mix, and the wife's brother is her Welfare Attorney [appointed under the LPA] with authority over life-sustaining treatments: so we now have the husband, the GP, a practice nurse, a 999 paramedic, the wife's sister and a brother of the wife who is also her welfare attorney present when the wife arrests.

This does change things: the relevant part of the MCA is 6(6) & 6(7):

6(6) Section 5 does not authorise a person to do an act which conflicts with a decision made, within the scope of his authority and in accordance with this Part, by—
(a) a donee of a lasting power of attorney granted by P, or
(b) a deputy appointed for P by the court.

6(7) But nothing in subsection (6) stops a person—
(a) providing life-sustaining treatment, or
(b) doing any act which he reasonably believes to be necessary to prevent a serious deterioration in P's condition,

while a decision as respects any relevant issue is sought from the court.

Nobody will have the time, when the wife arrests, to apply to a court, so we can discount section 6(7); it follows that if the wife's brother says 'in my opinion it is not in my sister's best interests for CPR to be performed', then nobody should attempt CPR. Technically, it appears that if anybody did attempt CPR when the welfare attorney had said 'don't do it', the person who attempted CPR would have no defence at all to a legal charge of 'assaulting the wife'.

The wife appointed her brother, because the wife wanted the brother to make those decisions. There is clearly an expectation that the brother would make the decision about CPR: but if everyone looks at the brother, and the brother just stands there and says or does nothing, then that in my opinion would not prevent the others from 'making and acting on their own decisions' - it is the expression of the welfare attorney's decision, that brings section 6(6) into play.

5) Now consider the situation when 2 or more people who are welfare attorneys are present.

In this situation, the further complexity of the nature of the attorney's authority is relevant.

If the authority of the attorneys is 'Joint' then their decisions are only legally-binding if all of the attorney's express the same decision.

If the authority of the attorneys is 'Joint & Several' then each individual attorney can make and express a legally-binding decision.

This is potentially very messy indeed, in the context of decisions about healthcare: I believe that originally the concept was for 'contracts' when it makes obvious sense (for example, if the attorneys are 'joint' then they all need to sign a contract for it to be valid: if 'joint & several', then the contract can be validly signed by just one of the attorneys, but all of the attorneys are bound by the contract. It would be possible to conceive of a situation when welfare attorneys possessed joint & several authority, and one attorney was expressing a decision about healthcare to a clinician, while at the same time a different attorney was expressing the opposite decision about healthcare to a different clinician - hugely 'messy' if the decision is being made 'in a clinical emergency'. Fortunately - probably 'hypothetical'!).

Since about 2014, I have been publishing my own 'Justification Hierarchy' for CPR - it is this, and you will note how careful I have been in what I say about multiple attorneys:

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

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

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

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

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

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

I usually explain that sequence in more detail, but as I've gone through the necessary reasoning in this piece before showing the Justification Hierarchy, I will leave readers to 'join the dots' themselves.

One perverse issue, is the fact that somehow since 2007, many clinicians have erroneously concluded that the MCA's requirements for ADRTs in sections 24-26 'have made verbal refusals of CPR not legally-binding'. **The idea is both annoying and also 'absurd, in a law which clearly sought to strengthen the patient's self-determination**'. But back in 2007, the Joint CPR Guidance did express the situation correctly (from its 'Main messages' section on page 3 with my own added bold: see 1 and 2 in my hierarchy):

*If a patient with capacity refuses CPR, **or** a patient lacking capacity has a valid and applicable advance decision refusing CPR, this should be respected.*

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