Mike's Cheeky Blog: should clinicians change to the simpler rule of 'attempt CPR if while capacitous the patient asked for CPR to be attempted'?

The behaviour around decision-making for cardiopulmonary resuscitation (CPR) is currently a confused mess – that statement is blunt, but definitely correct! We need to improve the situation.

I will examine some of the legal and logical issues towards the end of this piece, but I'm going to start with a question, from my own 'former family-carer of parents who were dying at home' perspective.

Suppose his GP was talking to my 'dying' father, and the GP said to my dad 'We are not going to attempt CPR if your heart stops, because we believe you are now so ill that it wouldn't do any good – attempting CPR would probably injure your body, and it is incredibly unlikely that it would keep you alive: certainly not alive and able to talk, etc'. And my dad said to the GP 'You are probably right – but I want you to attempt CPR if my heart stops, because I want that tiny chance of it keeping me alive'. And that my dad then turned to me and said 'If you think my heart has stopped, I want you to call 999 and ask them to try CPR – you will do that, won't you?'. What do you ('the NHS') expect me to do in this situation? Is it:

1) Argue with my **dying** father, or perhaps
2) Lie to my dad – say to him 'I'll phone 999 and try my best to get CPR attempted' – but then to take the GP aside and say to the GP 'I agree with you – I'm not going to call 999 and press for CPR' **and to live with a lie**.

I don't think I could do either – my instinct is that 'I could only live with' saying to my dad 'I'll do what you want – I'll phone 999 and I'll try my hardest to get them to attempt CPR'.

Moving on to the legal and logical issues with CPR decision-making.

It is clear that when a mentally-capable patient is involved in discussions with a clinician, the outcome of an offered treatment (the range and probability of the

various possible clinical outcomes – for short 'the prognoses') has to be described by the clinician, but then the patient considers whether to accept the offered treatment. So: if we thought about CPR in the context of Informed Consent, **'the predicted clinical situation after the CPR attempt' is considered by the patient during the patient's decision-making**.

Mr Justice Charles, in his Briggs ruling, has explained that if a potentially-successful life-sustaining treatment is being considered on a best-interests basis, then if it is believed to a sufficient degree of certainty that the patient would have refused the intervention [if the patient had been capacitous and able to consider it] then the treatment should be withdrawn/withheld. If the patient's likely decision cannot be worked out to a sufficient degree of certainty, then the best-interests decision defaults to attempted preservation of life.

There is a recent court ruling, which you can find here:

https://www.bailii.org/ew/cases/EWCOP/2018/39.html

and I came across it, when it was being discussed on Twitter: people were saying that 'the judge has ignored the fact that the doctors have said that CPR couldn't work, and the judge has ruled that CPR should be attempted'. I knew that couldn't be right – even before I read the ruling, I tweeted 'I suspect the doctors said CPR would almost certainly either fail or else leave the patient in a really bad clinical situation: BUT that is a factor to be considered DURING best-interests decision-making – the prognosis is only a factor, and unless you are CERTAIN THAT CPR would not restore life, the acceptability of the quality of that life to the patient is at the heart of best-interests decision-making'.

The judge, Mr Justice Keehan, therefore took into account his section 26:

> 26 I then heard evidence from FB. She gave very moving evidence of discussions that she had had with her mother prior to her admission to hospital on 17 July. This discussion arose because of a previous admission to hospital that HB had had to endure and which brought to her mind that it was time for a lasting power of attorney to be drafted. The lasting power of attorney was in favour of FB and FB in evidence told me that her mother had said to her that were she to become ill again, that she would want all possible steps to be taken to keep her alive. I have no doubt that FB is accurately reflecting the views that her mother conveyed to her. Those views are entirely in keeping with HB's religious and cultural beliefs. She is a practising Muslim.

when arriving at his ruling of section 36 (my own added bolds here):

> 36 I entirely accept those submissions and the force in them, but **key to the decision must be the wishes and feelings of HB and it is plain that administering CPR in the event of a further collapse and giving her, albeit a very, very small chance of life, is what she would wish**. In my judgment, at the moment, it remains in her best interests for that treatment to be provided to

her. I entirely accept that there will undoubtedly come a time when such treatments would no longer be in her best interests but I am entirely satisfied that that stage has not been reached yet.

Now – that was a best-interests ruling, which requires 'the working out of' 'the patient's likely position on the intervention'. But it looks very-much in line with my suggestion for capacitous patients – of 'if a capacitous patient says 'try CPR' then just try it – don't get deeply involved in trying to establish at the time of a cardiopulmonary arrest 'how likely is a good clinical outcome?''.

My proposed rule is a simple one:

'If a capacitous patient is understood to have requested CPR, then CPR should be attempted'

To be clear: I am saying that if a patient who is engaged with the NHS (for example, a known terminally-ill patient who is still at home, or a frail elderly patient who has been admitted to a hospital because of 'an emergency') is mentally-capable until a cardiopulmonary arrest itself removes that mental capacity, then if after having discussed CPR and thought about it the patient says 'I want you to attempt CPR, even if you think it wouldn't work' I consider that CPR should be attempted.

There are – being 'technical' – at least three reasons for my position on this:

1) I keep coming across clinically-authored literature which says 'CPR is a clinical decision' and **it is not** – our law is clear, and whether or not an offered treatment should be applied is explained by the MCA. Only if the treatment would have a ZERO SUCCESS RATE does a different legal concept, of 'it being pointless to offer a treatment which could not be successful', come into play. This is often expressed as 'patients cannot demand a treatment' – and it leads on to my next point;
2) CPR is unlike almost every other treatment – **and it is offered/attempted by default** within the NHS. In fact, it is remarkably difficult to prevent 999 paramedics from attempting CPR in community settings, if you are healthy and you have decided to try and exercise your legal right to refuse CPR. At the other end of the spectrum, some hospital doctors who treat elderly and frail patients, are very concerned with the question of how to prevent 'pointless and damaging' CPR being attempted on their patients. So it isn't as if NHS clinicians are reluctant to attempt CPR – and frequently CPR will have been attempted, when with hindsight everyone agrees that it would have been better to instead let the patient die in peace;

3) Being VERY NERDY INDEED [to the point that I seriously considered not including this] there is a logically-correct, but so far as I am aware 'never discussed', further justification for not attempting potentially 'successful' CPR. In principle, because the NHS has limited resources and must be fair-to-all, there is an issue with not 'clinically awful' but 'expensive for the NHS' outcomes. If CPR leads to a patient who is subsequently 'permanently comatose and requiring ongoing and very expensive aftercare', then (and the existence of NICE 'proves the logic here') arguably a defensible position would be 'CPR might work, but if we attempted CPR it might also result in aftercare costs which are simply too high for the NHS to bear if we are to be fair to all patients'. HOWEVER: it seems to me [and I do not have the evidence for this] that such an outcome is probably more likely the healthier the patient is before the cardiopulmonary arrest – in other words, that consideration even theoretically would apply more to attempted CPR of healthier patients, than it would apply to patients for whom attempted CPR would almost certainly not re-start the heart.

And, returning to a 'less nerdy' argument: it is well understood that 'discussions about dying' are typically difficult to embark on for everyone involved during end-of-life, and discussion of CPR falls into that category. If a nurse asks an elderly patient about CPR, some relatives will immediately object '… but dad isn't ill enough to be talking about CPR!'. This 'CPR is a clinical decision' claim which I keep coming across, is not only legally incorrect as I have explained previously, but it also supports 'thinking by' clinicians that the patient's clinical situation, if bad enough, means that the clinicians can legitimately avoid trying to talk to patients and/or relatives and friends about CPR – and a switch to 'attempt CPR if the patient asked you to attempt CPR' would in my opinion help to promote these tricky discussions.

Written by Mike Stone, November 2019.

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All typos are my own.

For a short piece pointing to various of the problems around CPR, I would point the reader to my BMJ piece here:

https://www.bmj.com/content/352/bmj.i1494/rr-3