This thread (the original post) was being discussed on Twitter (28 November), and I will ‘give the ‘gist’’ of the tweets here. It is always difficult to ‘transcribe’ discussions on Twitter because they usually become fragmented, and I also posted quite a few ‘text images’ (screenshots of the text on a computer screen, converted to a JPG image and attached to my tweet) some of which I will not be showing here. But I will attempt to ‘fill any gaps’ - at least to the point where the thrust of the discussion is clear.

Ken Spearpoint’s background, is that of a consultant nurse with a specialist expertise in cardiopulmonary resuscitation (CPR). Kate Master’s family won a famous court ruling (the Tracey case – it hinged on hospital doctors putting a DNACPR form in the notes of Kate’s mum, without telling either Kate’s mum or her family). Mark Taubert is a doctor, who writes a lot about CPR.

I tweeted a link to this thread, and said ‘my suggestion – clinicians should attempt CPR if a mentally-capable patient asks them to, even if the clinicians think CPR wouldn’t work – is a serious one’, and Ken tweeted:

Mike, there is legal precedent in this situation. Doctors cannot be compelled to undertake treatment that they know to be ‘futile’. Patients cannot legally demand CPR.

I tweeted:

I am aware of that - read my PDF, and ponder the recent court case I provide a link to in the PDF. There is a logical issue with that word 'futile' - post-MCA it should be '100% clinically ineffective' in my opinion.

Ken replied with [and I have added the bolds here]:

Good point re ‘futile’ never particularly comfortable with that word. The issue of ***capacitous people being able to ‘demand’ medical treatment (CPR) that a body of evidence, knowledge & expertise know will not work when someone is dying is, I would argue, ethically abhorrent****.*

I tweeted:

The thing is - you almost never 'know CPR could not restore some sort of life': usually you only know 'the prognosis is extremely poor'. So - if the patient is decapitated, then clearly no CPR. But if the patient is ill/frail - a different situation.

Ken tweeted:

There is no law that I am aware of that enables a capacitous patient to demand / compel a doctor / HCP to conduct CPR if they hold an informed, experienced, knowledgeable professional judgement that there will be no benefit to the patient.

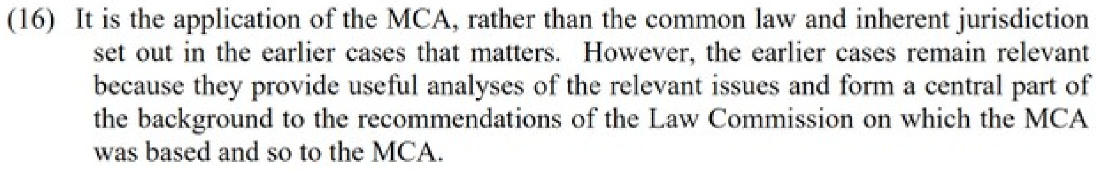
I tweeted:

That is true - there is also no law which allows a clinician to prevent a family-carer from attempting CPR, even if the clinician believes CPR wouldn't be successful. Something I'm not sure the police understand. See https://dignityincare.org.uk/Discuss-and-debate/download/343/… for my analysis

I tweeted:

When was that legal precedent by the way - was it before the MCA was enacted? As Mr Justice Charles pointed out in his Briggs ruling https://judiciary.uk/wp-content/uploads/2016/12/l-briggs-v-p-briggs-others.pdf… - 'I am required to apply the MCA'. And I'm arguing 'it would be MORE SENSIBLE to' - not 'it is legally clear you must'.

And this text image was attached to that tweet:

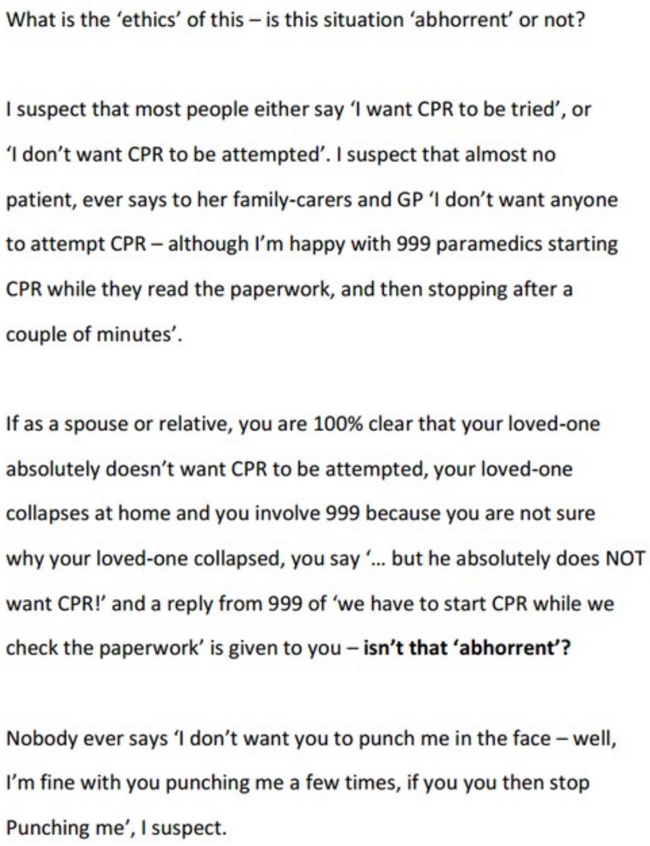


(16) It is the application of the MCA, rather than the common law and inherent jurisdiction set out in the earlier cases that matters. However, the earlier cases remain relevant because they provide useful analyses of the relevant issues and form a central part of the background to the recommendations of the Law Commission on which the MCA was based and so to the MCA.

I also tweeted:

Do you think it is equally 'abhorrent' that currently https://bmj.com/content/356/bmj.j1216/rr-1… the law says a healthy person can forbid CPR, the person can explain that to a partner and the GP, and SUBSEQUENTLY the partner will probably discover that 999 would attempt CPR?

This text image was attached to that tweet:



What is the 'ethics' of this – is this situation 'abhorrent' or not?

I suspect that most people either say 'I want CPR to be tried', or 'I don't want CPR to be attempted'. I suspect that almost no patient, ever says to her family-carers and GP 'I don't want anyone to attempt CPR – although I'm happy with 999 paramedics starting CPR while they read the paperwork, and then stopping after a couple of minutes'.

If as a spouse or relative, you are 100% clear that your loved-one absolutely doesn't want CPR to be attempted, your loved-one collapses at home and you involve 999 because you are not sure why your loved-one collapsed, you say '… but he absolutely does NOT want CPR!' and a reply from 999 of 'we have to start CPR while we check the paperwork' is given to you – **isn't that 'abhorrent'?**

Nobody ever says 'I don't want you to punch me in the face – well, I'm fine with you punching me a few times, if you you then stop Punching me', I suspect.

Ken tweeted:

Ethically yes, it is equally abhorrent to conduct CPR against a capacitous persons wishes. The situation is however different, because HCP's are required to do this currently (in some circumstances) where hindsight may have guided them to have acted differently.

I tweeted:

So - HCPs are REQUIRED to do 'abhorrent things'? No - they aren't (section 42 of the MCA allows for 'agreement to do things 'better'' in theory).

Ken Tweeted:

That is about interpretation, philosophy, personal belief systems and personal ethics. I have pain in my right lower groin, as a capacitous person, can I demand an appendicectomy?

I tweeted:

No - but unlike CPR, which for practical purposes 'is attempted by default' outside of hospitals [and more often than it should be, inside hospitals], surgery is very rarely attempted without significant prior discussion. And - 'the NHS' implies you would be offered the surgery.

Kate Masters tweeted in response to Ken's question:

No, but a lay person couldn't provide it either! And that is where I think CPR is very different consent wise. It's left the 'clinical decision making ' building because everyone can (and is encouraged to) do it!

Ken tweeted [presumably in response to my tweet about the difference between in and out of hospital]:

Therein lies the challenge, it shouldn't be different? I am confident that we are moving (albeit slowly) in the right direction.

I made the point in a tweet, that even without a new statute 'the law moves on' by pointing to Lady Hale's 'appendix to' the Montgomery ruling, and Ken tweeted:

Understood, but the context is not the same (in my opinion). The law is of course dynamic, it it also incredibly complex, subjectively interpreted and extensively argued. I stand by my original view.

And I tweeted:

That is the problem - we all tend to 'stand by our views': which is hugely problematic for End-of-Life-at-Home if there are family-carers involved. Which is why I write pieces such as this one https://dignityincare.org.uk/Discuss-and-debate/download/360/… to try and find perspective-balanced 'compromises'.

Ken then tweeted the following – and this led to something of a diversion from the original topic, as you will see:

My position is constructed from a professional, experienced, legally-informed position. As you know, I have published & researched & advised in this area for some time. It is not a 'lay' opinion.

I tweeted:

Kate and I have both put in a bit of effort, towards gaining some understanding of the decision-making around CPR - although Kate tends to [in my opinion] 'downplay her own expertise'. So are we expressing 'lay opinions' - or simply informed opinions, from a lay perspective?

Mark Taubert tweeted:

I don;t think you could ever describe yourselves as lay, after all the experience you have gained over the years. In fact, quite the opposite!

And Ken tweeted:

Not at all a 'lay' opinion, it wasn't my intention to imply that. Kate knows my long term supportive position very well. I have utmost respect for your views / input - it is crucial to have & such voices as yours.

And I tweeted:

I don't describe myself as a typical layman - I describe myself as a lay analyst with a family-carer or patient perspective. More to the point, is whether most HCPs would consider people such as Kate and me to be 'layfolk for the purpose of these debates'.

COMMENT ON THE TWEETS

What these tweets reveal – aside from how complex the law around CPR is – is what I will describe as 'perspective differences'. We all 'see the same contradictions' between different objectives – but we do not all 'order' those contradictions the same way. When things are in opposition to each other – when there has to be one objective giving way to another objective, while in themselves both objectives are clearly sensible – Ken is not prioritising the objectives in the same order that Kate and I are prioritising them.

And, I will make something clear: I almost agree with Ken – performing CPR on a patient if you knew that the result would be 'a lingering and painful or distressing death' is 'abhorrent'.

There is obviously a reason why our heart, lungs, etc are protected by our ribcage – and CPR will often break ribs, puncture lungs, etc, even if it initially 'restores life'. Many frail and ill patients in particular, who 'are dying naturally and peacefully', might be temporarily restored to life by CPR. But that life might include brain damage, mental capacity but serious pain, and many combinations **but with an inevitable subsequent death in a matter of days**. The damage caused by the 'successful' CPR, can lead to infections and other clinical complications, which the patient simply cannot survive, even with the best-possible post-CPR medical and nursing care. That is horrendous – watching your peacefully-dying loved-one being restored to life by the quite brutal process of CPR, only to watch your loved-one suffering for a few days and then dying anyway.

I have also been reading the draft of something a charity is currently working on, and the e-mail I've recently opened after I had sent some comments on the draft ended with this sentence:

The primary objective is to get more people talking about later and end-of-life care. If we can do that, and avoid providing misleading or factually incorrect information, then we shall have done some good!

That is 'spot-on' - and while I think the arguments I laid out in the first PDF in this thread make a logically-compelling case for the change I'm proposing, I honestly think the change would 'get more people talking about later and end-of-life care'. I did NOT suggest that a patient could say **out-of-the-blue** 'I want you to attempt CPR' and that would not then lead to a discussion – if a patient said that to a doctor, and it wasn't after a conversation around 'we don't believe CPR could work for you', I would expect the doctor to explain what sometimes happens if CPR is 'successful': to explain that 'lingering death' I have described above. I suspect that then, many patients would say 'I don't want CPR then!'. Some patients would always want CPR. But at the moment, I'm told that understanding of the clinical consequences of CPR among patients and relatives is often very poor – I think if the position was that capacitous patients would have CPR attempted if they asked for it, despite the clinicians thinking it would have a very bad clinical outcome, then there would necessarily be more discussion about CPR, and increasingly a better understanding within lay people of CPR.

After all – as Ken said 'capacitous people being able to 'demand' medical treatment (CPR) that a body of evidence, knowledge & expertise know will not work when someone is dying is, I would argue, ethically abhorrent' so surely doctors and nurses, would [at least try to] make clear the likely outcomes of CPR when attempted on patients who are very frail, or are 'naturally dying'.