

‘Should’ and ‘Must’

When you read the end-of-life, and CPR, guidance for clinicians, and also social media discussions of those topics (Twitter is good for that), the words ‘should’ and ‘must’ frequently appear. As a layman, I will read that a doctor ‘should do “whatever” and sometimes that a doctor ‘must do something’.

In reality, most behaviour hardly ever comes down to ‘must do’ - and ‘should do’ leaves a lot of ambiguity if that ‘should’ isn’t done. And the complexity here, stems from our law: our law often leads to ‘should’ and very rarely leads to a straightforward ‘must’. And to boot, we will often see it stated that an Advance Decision ‘is legally binding’. More correctly, an Advance Decision which is valid and applicable ‘is legally binding’. Valid is reasonably simple (it means signed, witnessed, etc) but ‘applicable’ leaves an awful lot of scope for ‘wriggling out’ of following the ADRT. In reality, the only clear way that a clinician would definitely be in trouble for not following an ADRT, would be if the clinician actually stated ‘I decided the ADRT was valid and applicable, but I decided to ignore it anyway’: *and only an idiot would admit to having done that.*

We layfolk read that doctors ‘should’ discuss DNACPR decisions with patients and/or family and friends – but, often to the subsequent annoyance of usually then-bereaved relatives, if the DNACPR decision is not discussed with the patient and/or family, there is wriggle room for the doctor: it is only ‘should’ discuss, it isn’t an absolute ‘must’ discuss [although the law tries to limit the exceptions which make it weaker than ‘must discuss’].

We layfolk are also given quite copious ‘advice’ about what we should, and can and cannot, do during end-of-life, by clinicians and clinical organisations. The issue here is slightly different: normal family and friends are subject to fewer ‘musts’ than the clinicians, and furthermore many of the things we are told by professionals that we ‘should’ do, are not strictly ‘should do’ and are in fact a mixture of things which ideally we would do, and things which make life easier for the professionals if we do them.

On Twitter, people often ask ‘what are the rules for DNACPR – what MUST doctors do?’ and it is really difficult to answer that type of question. The simplest answers are along the lines of ‘... it is good practice for the doctor to ...’ but, of course, almost always the person who is asking the question, is asking because their particular doctor departed from that description of ‘good practice’.

I feel pretty sure the above is in fact correct – but I admit I have cobbled it together very quickly, because I wanted to see if I can upload PDFs from my mobile phone to Dignity in Care.