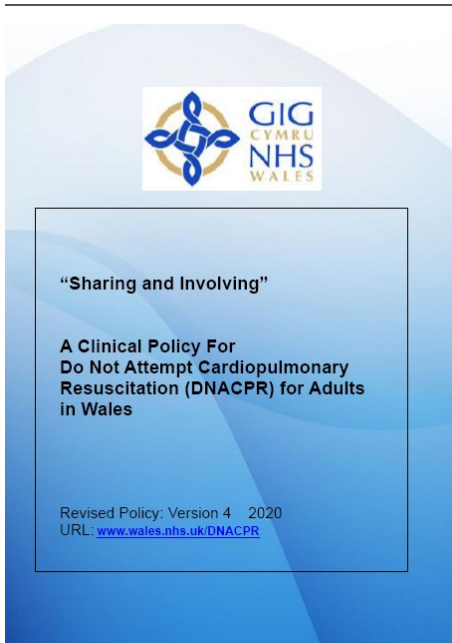


Some Comments on the DNACPR Policy in Wales

I am going to make some comments on the policy for DNACPR in Wales – judging by its first page you should be able to find it at:

www.wales.nhs.uk/DNACPR



This is a long document, and my comments – which as usual come from my family-carer during end-of-life-at-home perspective – will mainly be written with the context that the Mental Capacity Act is the law in Wales, as it is in England.

I will also be ‘asking questions’ about the internal coherence and consistency of this policy: in fact, there could well be some internal contradictions which I do not notice, because having read only about 10 pages and glanced at its DNACPR form I was already ‘irked’. And when a document has already irked/annoyed me, I tend to not spend a lot of time reading it in detail (probably a failing on my part!).

I will be commenting ‘as I read’ - forgive me if this isn’t what you (the reader) would have preferred.

Page 4 of the policy (its first ‘real’ page) is fine, except for:

Inappropriate attempts at CPR can lead to unnecessary torment for patients, their family and trusted friends, may involve the ambulance service and even the police, which may cause further distress.

There is a lot ‘wrapped up’ within that sentence, including ‘... even the police’. The police, should not become involved in ‘expected community death’ - because the police are usually involved with ‘sudden’ death, their ‘expectations and mindset’ can be deeply unhelpful and problematic if involved with an expected death. But *if a death is expected, then the death is still expected even if someone attempts CPR*. I’ve seen policies which imply that if CPR has been attempted, the death cannot have been expected. This is logically untrue – we need to have sensibly-designed Expected Death policies, and also we need to have CPR/DNACPR policies: but they are NOT the same thing. Conceptually it is perfectly possible for a clinician to have the position of ‘CPR almost certainly would not work, and you are very close to death – but, as you are forcefully in favour of CPR being attempted I will attempt CPR’. That position (assuming the clinician could certify the death) amounts to ‘Your death is ‘expected’ but nonetheless I am willing to attempt CPR’.

We should NOT regard the presence of a DNACPR document as being ‘a proxy for expected death [status]’ - especially as the DNACPR form in Wales (see page 35 of the policy) has ‘Patient refused CPR’ as a reason for the DNACPR. Clearly patients have the

legal right to forbid CPR even while they are in good health – and that cannot be an expected death.

NOTE: I am using 'expected death' in a technical sense here. It doesn't mean 'the family were expecting the death'. It means, in essence, 'the patient's GP has agreed in advance to certify the death'.

I liked this sentence on page 4:

The focus is on respect for the wishes of individuals in order to facilitate the provision of appropriate care near the end of life and the need for discussions to take place in a shared and planned way, at an earlier stage, across all settings including the home and community.

I also like this sentence which runs over from page 4 to page 5 (although I would start it with 'When' instead of 'While'):

While death is inevitable, achieving a dignified, sensitive and shared approach in the understanding of CPR and its likely success or failure, is vital for patients and those close to them/concerned with their welfare.

But I don't like this sentence which follows the above:

DNACPR decisions should always involve experienced professionals, with knowledge of this policy and training in communication of serious illness conversations.

To me, a 'DNACPR decision' is a decision that CPR should not be attempted – if a patient decides that, and creates an Advance Decision refusing CPR, which can legally be done without involving any professionals (experienced or otherwise), then that is 'a DNACPR decision'. I think that sentence should instead say the following:

Discussions about CPR /DNACPR which are initiated by professionals, should always involve experienced professionals, with knowledge of this policy and training in communication of serious illness conversations.

I don't like much of the rest of page 5 of the policy. It is very 'Curate's egg' when I read it. I have a particular problem with this sentence, which is what I will choose to analyse:

The patient's fully informed personal perspective on CPR is of great importance, viewed in the wider clinical context.

Capacitous patients have a legal right to refuse CPR however healthy or ill they are, and if CPR could not restore life then clinicians are under no legal duty to attempt CPR. **The above sentence, correctly reflects neither situation.**

I'll pick out a sentence on page 6:

To ensure correct and effective communication to all those involved in the patient's care.

'All those involved in the patient's care' is a term which must include family- carers during EoL-at-Home. There is potentially a problem around 'confidentiality', which I'll let the reader think about by means of giving a few 'clues':

- * A patient at home, could say to a GP 'I'm telling you – but you must not tell my daughter who lives with me;
- * A patient at home who lives with his daughter, could say to his daughter 'I'm telling you – but you must not tell my GP';
- * If a patient becomes incapacitous without having explained what he would want in the context of future medical interventions, it isn't possible to apply MCA 4(6) unless the medical options and prognoses are explained to 'those who know the patient as an individual' (this is true, whether or not the patient has said 'If I lose capacity, do not disclose medical information to my family and friends);
- * A GP cannot 'tell a family-carer what to do if the loved-one/patient arrests: family-carers take 'instructions' from capacitous patients, or need to apply the MCA's best-interests concept.

This sentence, on page 6, really angers me:

To clarify that patients, contrary to occasional media reports on this issue, are never asked to sign DNACPR forms themselves. The form has only healthcare professional signatories.

WHY? Why is the RC(UK), and it seems 'the medical establishment', so determined to keep the signatures of patients, welfare attorneys and relatives off DNACPR forms?

At the start of section 2.5 on page 7 we can read (my added reds):

The Mental Capacity Act (MCA) 2005 Section 1(2) recognises the basic principle that **an adult must be presumed to have the capacity to make their own decisions**, unless it can be established that they are not able to understand, use, or weigh up the information needed to make the DNACPR decision and/or communicate their wishes.

Why if the patient makes her own decision about CPR, and if that decision is to be recorded on a DNACPR form, is 'the system' so determined to prevent the patient from signing a document recording the decision?!

This 'patients do not sign DNACPR forms' is trotted out, without any convincing 'why' being given – it seems to me to be akin to someone saying in 1900 'Women don't vote'.

I'm tempted to analyse this on page 8, but it would take too long to do it properly:

Note that neither the patient, nor anyone on their behalf can insist on treatment that the clinical staff do not feel is in their best interests *even* if such insistence is included in a written document.

The following is on page 8, and whoever wrote this should be ashamed – it is hopeless!:

2.8 Lasting Power of Attorney for Health and Welfare or Court Appointed Deputy

Both of the above may have legal powers to assist with the decision making process where the patient lacks decisional capacity. However, care should be taken to check the validity of any held documentation and the scope of their powers. Where such persons are considered not to be acting in the patient's best interests it is important to seek legal advice. The Office of the Public Guardian has detailed information on this.

In a nutshell, and ignoring some 'hotly contested' issues around the idea of a DNACPR decision being made in advance of the actual arrest, the situation is:

- * [Health and] Welfare Attorneys are appointed TO MAKE best-interests decisions, and CAN possess 'legal authority' over CPR (sections 6(6) and 6(7) of the MCA);
- * Court Deputies CANNOT possess legal authority over CPR best-interests decisions;
- * If CPR definitely could not be successful in restoring life, then [it is usually accepted – see footnote] CPR will not normally be offered – so nobody is making a best-interests determination.

The first sentence of section 2.8 does NOT reflect the law – it is quite simply wrong.

FOOTNOTE. If it were absolutely certain that CPR could not restart the heart, but a patient said 'I accept that – but nevertheless I want you to attempt to CPR' AND if the patient's final days or weeks of life would be 'ruined/haunted' by 'I want them to try CPR and they won't!' then what exactly would be wrong with saying 'okay – I'm sure CPR couldn't work, but as my refusing to attempt CPR will upset you for the rest of your life, I will attempt CPR when your heart stops'?

We do of course get into 'can a doctor be 100% certain that CPR would not be successful in restarting the heart', and into a discussion of 'abysmal post-CPR clinical situations' and that is rather the point - 'abysmal post-clinical situations' should be considered within either Informed Consent or Best-Interests determinations. And, while 'CPR could never work' does indeed require clinical expertise, that is an expert prediction – it isn't in fact a decision.

On page 9:

It is recognised that there may be exceptional clinical circumstances when a first responder has to make an immediate decision that favours the right to life with no time to evaluate DNACPR status, hence providing CPR as the clinical situation demands.

I am not going to discuss that in detail here – and I am actually in the process of attempting to discuss this with England's College of Paramedics. I will say, that it isn't 'quite' the 'right to life' replacing MCA Best Interests [as the above might imply] – it is that 'preservation of life' is within the MCA's best-interests provisions.

4.1 on page 9 is rather lax in its use of the word 'decision' but I'm not going to dig-into that here.

Section 4.2 goes over the ground I have already written about in my 'FOOTNOTE' on the previous page.

I'm intrigued by this, on page 10:

All competent patients have the right to decline to participate in DNACPR and Advance Care Planning discussions. Furthermore, they can refuse permission to share the outcome of any such discussions with any third party. Such decisions must always be respected and documented in the patient's records. A clinician should not force information on a patient which is likely to cause harm. A risk of harm in this context, or an indication from the patient that they do not wish to be informed about CPR, must be justified in the clinical record.

Does that mean that a capacitous patient can forbid the creation of an ACP, FCP, TEP, ETP, ReSPECT form, etc? And, if I have a discussion with a doctor, is a 999 Paramedic or a Ward Nurse 'a third party' as mentioned in the second sentence? We are getting into 'quite deep water' here – I'm throwing the observation/questions in, but I'll leave the reader to ponder them.

On page 11:

It should be kept in mind that a patient who agrees to take their DNACPR form with them to their own home, should consider that sharing this information with those close to them will likely be necessary; in order for the existence of the form to be adequately communicated to any arriving clinical staff, such as paramedics, someone from the household will need to be aware of its existence and where it is kept.

That makes me think back to about 2010, when many hospitals were not keen on disclosing 'Clinical DNACPRs' to patients. I pointed out to my PCT that if a DNACPR form was at home, it was very likely that the patient (and people living with the patient) would become aware of it. We had a rather perverse situation, when patients at home were likely to be aware of Clinical DNACPRs but patients in hospital [in similar clinical situations] were not being told of Clinical DNACPRs. NOTE: 'Clinical DNACPR' means a form founded on 'CPR couldn't work' (at least, when I write 'clinical DNACPR' that is what I mean).

I like this wording, with the 'quotes', on page 11:

If the decision is to be made because 'CPR would not be successful',

I'll throw in a comment here: I've just done a word-search for 'Briggs' and it didn't return anything. You really should point at the 'Briggs ruling' by Mr Justice Charles in your 'references' (translation from continuation of CANH, to application of CPR, is a simple and obvious one).

I'm not happy with this (here in 4.5):

patient's own ADRT or Advance Statements or letters from other clinicians about discussions held, can be appended to the relevant form.

An ADRT refusing CPR, **should be clipped on top of** a DNACPR form – as the policy points out, if valid and applicable an ADRT is legally binding [whereas the DNACPR form

isn't]. There should be no need to look at a DNACPR form while considering CPR, if an ADRT refusing CPR is considered applicable: it isn't 'some sort of discussion - 'the ADRT settles the matter'.

From 4.6:

Immediate and effective communication of a DNACPR decision must take place so that all those involved with current and future care are made aware.

As I have mentioned already – family-carers must be within 'those involved' if you want coherence, and not chaos, during EoL-at-Home.

I really like section 5.1 on page 12 of the policy.

5.1.2 is tricky – I'm not going to discuss it here (that is probably the trickiest issue of all around CPR to analyse correctly), and instead I will discuss it in an Appendix.

A 'general comment': I think rather too much emphasis is being given to 'Natural Anticipated and Accepted Death (NAAD)'. I would also point out, that this sentence in the policy is a little odd: 'NAAD is a clinical concept, which may help clinicians and patients in partnership reach a shared position from which a DNACPR discussion and documentation can follow'. The oddness doesn't rest on the situation – it rests on the inclusion of '... and accepted' **within the terms definition**: the patient, and or family, might not 'accept' that a death is imminent – that doesn't affect the imminence of the death, and it isn't really 'a clinical concept'. Perhaps I am being picky about the word 'concept' - I would accept 'NAAD is a term, used for a situation when clinicians believe that a natural death is imminent and patient, and/or 'family' if the patient lacks capacity, accept that death is imminent'.

I like 5.3 except I dislike how it moves from 'THOSE close to the patient' to 'A named INDIVIDUAL'. Let the patient name SEVERAL individuals, if the patient wishes to do that.

I don't like this sentence in 5.4:

If a patient lacks capacity and a decision is made in his or her best interests in accordance with the MCA, then the clinical rationale and justification for the best interest decision should be clearly recorded in the notes for instance by way of a best interest's balance sheet if at all possible.

Best Interests determinations involve consideration of the clinical situation – usually possible interventions and their prognoses, and the prognosis with no intervention – but that is information about clinical factors. It isn't, to my mind, correctly described as a 'clinical rationale' which 'rather implies' that the clinical factors are reasons, rather than information to be considered within the best-interests process.

I will discuss 5.5.1 in the appendix.

I like this in 5.5.2:

The term 'sick enough to die' has been used in such situations (*Mannix K, "With the End in Mind" 2018*).

Partly I like it, because 'sick enough to die' is an excellent phrase and description – and partly I like it, because I'll be able to Direct Message Kathryn and tell her the phrase is in the policy.

Also in 5.5.2 (and clearly correct):

in the context of the patient's condition, death might be considered to be clinically inevitable in the days, weeks or months to follow.

I will comment, somewhat as an aside, that in the context of 'Community Expected Death Policies' an inevitable death within MONTHS is not currently handled properly.

This is wrong, in 5.5.3:

A patient aged 18 or over, may have a specific Advance Decision (ADRT) in place with previously expressed wishes withholding permission to attempt CPR in the event of cardiac arrest (see 5.2.3).

An ADRT is NOT 'a wish'. The clue is in the title – it is a DECISION.

Do a word search of sections 24-26 of the MCA for 'wish' or 'wishes' - neither word appears.

One might think that the first thing in section 24 would give a clue that the patient is recording a decision, not a 'wish':

"Advance decision" means a decision made by a person

I also dislike this sentence:

Otherwise they must be asked and consulted, and may even state the opposite to what their ADRT has laid out, which should prompt a review.

'Prompt a review'? What is should prompt, is 'Are you retracting your Advance Decision – or have I misunderstood what you just said to me?'

I like this in 5.6, in terms of its logic around 'competence':

In such situations, it is recognised that it would be artificial, were such a healthcare professional to decline to continue such a conversation, purely because they consider it only appropriate for a Consultant or GP to lead on, or feel that they are unable to sign a form. **If a healthcare professional is deemed competent and qualified enough to have an in-depth discussion with patients about CPR, then they must also be seen as competent and qualified to make and record a DNACPR decision, in essence as a record and product of the conversation they have just had.**

Although, the issue of recording a DNACPR decision is trickier: and, if you think about it, being competent to hold a conversation about the clinical situation which informs 'DNACPR decision making', is not sufficient as a qualification to make a DNACPR decision. In any event, this is in the context of the DNACPR form which appears on page 35 and 'Patient refused CPR' appears on the form as a reason for DNACPR: which to me is 'the patient deciding, and the clinician recording'.

This is interesting, in Audit point 11:

Feedback from workshops held in Wales has stated that DNACPR forms with two signatures, especially when these are multi professional, engender a greater level of confidence in readers who review a patient at a later time point, so seeking a senior responsible clinician signature on a DNACPR form should be seen as best practice.

I'm not going to discuss this – but when I read that sentence, my interest immediately falls on 'engender[s] a greater level of confidence in readers'.

On page 21:

Where they are temporarily unable to physically sign a DNACPR form, that has been discussed, filled in and signed by a colleague in section 5, they can verify this decision verbally by telephone/video-link, and ask the colleague to document this dialogue on the form and countersign on their behalf.

Just a thought – while it is a little tricky (clearly the person who signs section 5 will have explained why to the senior responsible clinician) wouldn't it be better if a colleague other than the person who signed section 5, 'countersigned'? Perhaps – I'm not sure – that is the intention: if so, I find the wording unclear.

Section 5.8 starts with:

5.8 Senior oversight for every DNACPR decision including out-of-hours

The senior responsible clinician is responsible for overseeing the documentation and communicating decisions.

And Audit point 11 states:

For DNACPR to be recognised in Wales (outside of a valid and applicable ADRT) the All Wales DNACPR form (see Section 6) must be completed. It forms the record of the DNACPR discussion.

If I'm capacitous and I've got an ADRT refusing CPR that is definitely 'DNACPR documentation' and the senior responsible clinician is most certainly NOT responsible for 'overseeing' my ADRT – **I am responsible for 'overseeing' my own ADRT!** Be clear – this 'oversight' assigned to the senior responsible clinician is for YOUR DNACPR form.

I could embark on a discussion of 'oversight of' a written ADRT refusing CPR after the patient has lost capacity – but I'm not going to.

I am rather baffled by this, in section 5.9:

The senior responsible clinician who signs or countersigns a form is clinically responsible for the agreed position.

I would like to know what the presence of 'clinically' in the sentence indicates – because if 'clinically' is removed, the sentence is apparently making one individual responsible for an agreed position. 'We all agree to go to Pub X [instead of to Pub Y]' - a typical agreement – is not 'the responsibility of' anyone in particular.

The wording in the main body of 8.2, is not as correct as the wording at the start of the Audit point [which follows]:

When clinical circumstances are NOT those envisaged during the original DNACPR discussion

The 'main text' seems to imply that it is the emergency that makes the decision not applicable – in fact, and only the Audit Point's wording makes this clear – it is whether the situation of the emergency had been considered or not when the DNACPR had been recorded, which affects its applicability.

I accept – especially standing where a 999 paramedic stands – that it is challenging to 'work with' the conceptually-correct description above: but I think a Policy should try to be conceptually correct.

I have just got to section 8.3 – and I'm 'shell shocked'! **In a good way.**

I can see [and approve of] this (the sentence after the dots which indicate that other text appears between the two) sentence in section 8.3:

A patient might insist that future CPR is provided - even when (for clear clinical reasons) the clinical team feel it to be an intervention which cannot provide clinical benefit and will not be successful... In some cases a multi-professional team review might resolve to follow the patient's wishes in an individual case, and to provide CPR, even if it is felt that it will not work or even potentially cause harm.

This – which I support [and which I'll further discuss in the appendix] – is not a sentence I can recall ever coming across in 'CPR policies'. What I repeatedly do come across, is what can be found in 5.1.1:

A patient cannot demand a treatment that is not clinically indicated. To provide CPR in such circumstances as described above would be futile. The decision is a clinical one centred on the clinical picture at the time. The position should be communicated to the patient (see section 4.3) and, with consent, to those close to them.

There are issues with the word 'futile', but the wording in 8.3 clearly describes 'futile CPR' and despite that CPR can be offered/attempted in 8.3 – whereas it doesn't seem to be on offer in 5.1.1.

So: deeply internally contradictory, but 'WOW' re 8.3!

8.5:

All forms in the UK, including the **ReSPECT** form in England and DNACPR forms in Scotland, constitute a valid clinical record of a decision process, when they have been filled in clearly and conscientiously.

The ReSPECT form does not record 'decisions' (unless we consider 'the decision to make a recommendation') so I am unhappy with this 'lumping together' of different forms.

Whilst DNACPR forms (including the All Wales DNACPR form, the ReSPECT form and other UK forms)

The ReSPECT form isn't 'a DNACPR form' even if we set aside the traditional/historical legal issues around 'DNACPR forms' - we really do need to encourage/promote the greater use of ADRTs in the context of DNACPR.

I really approve of the bolds in section 9:

DNACPR training applications, **emphasising the importance of good communication with patients and those closest to them**, should be made available via Local Health Board and Trust intranet systems for instance via *ESR (Electronic Staff Record)* and *Learning@Wales*.

The rest of section 9 looked pretty-good to me, as well.

I'm not going to comment on section 10 – somewhat outside of what 'expertise' I possess, so I'll leave that section.

A few comments on the DNACPR form.

I'll start with something I rabbit-on about, which is that I want the signatures of non-clinicians on these forms. Put simply, what I said in the second part of my BMJ rapid response here:

<http://www.bmj.com/content/352/bmj.i26/rr-5>

In section 1, we have:

Are you aware of a valid Advance Decision to Refuse Treatment (ADRT) refusing CPR which is relevant to the current condition?

While the validity (is it witnessed, etc) of a written ADRT can be assessed as soon as it has been created, in principle its applicability – or, loosely, 'relevance' - must in theory be considered at the time the treatment would be applied. This example would be 'odd' but is perfectly legitimate: 'I refuse CPR on Sundays'. A more realistic example would be 'I refuse CPR if I arrest when I am not inside a hospital'.

Really, I think it should just say 'Are you aware of a valid Advance Decision to Refuse Treatment (ADRT) refusing CPR?'

Also in section 1:

YES / NO

Has the patient appointed a Health & Welfare Attorney to make decisions on their behalf?
If "YES" they must be consulted.

A welfare attorney may, or may not, have authority over best-interests decisions about CPR. Section 4(7) of the MCA can easily be misunderstood: **it isn't saying** that an attorney with powers over CPR must be consulted. It is clear from section 4, that such an attorney is the person who would be 'doing the consulting' - the attorney would be required to consult doctors and others. However, if an attorney does not have powers over CPR, then anyone else seeking to say 'I acted in the patient's best interests' should consult with such an attorney.

I am not going to further comment on the form: if a form were designed which allowed, for example, a welfare attorney to sign if the reason for DNACPR was a best-interests decision, then the form would require a major redesign. On its own terms, the form is a good one.

APPENDIX

I said I would discuss 5.1.2 and 5.5.1 in this appendix, and that I would further discuss the sentence in 8.3 which I strongly approve of.

At this point, I will point the reader to a PDF I recently published at:

<https://www.dignityincare.org.uk/Discuss-and-debate/download/449/>

5.1.2 If the potential “adverse effects” of CPR outweigh any potential benefits

Even if CPR might possibly restore circulation and breathing, the benefits of prolonging life must be balanced against the risk of harm, pain and discomfort to the patient. The individual may only survive for minutes or hours. The patient’s recently expressed wishes are very important to ascertain. Teams, in this case, should also consider whether a natural and anticipated death free from the invasive interventions involved in the process of CPR, may be in the patient’s best interests. Such a view that a Natural Anticipated and Accepted Death (NAAD) is likely in the coming weeks or months, may trigger a discussion about ceilings of treatment, including whether CPR should form part of future considerations, or not.

Audit point 4 – Consider the possibility of “NAAD / DNACPR”

All salient clinical aspects must be considered and discussed in order to help reach a clinically informed and a shared understanding. It may be possible to conclude that the situation should be managed as a Natural Anticipated and Accepted Death (NAAD). NAAD is a clinical concept, which may help clinicians and patients in partnership reach a shared position from which a DNACPR discussion and documentation can follow.

5.5.1 DNACPR Decision

In some cases it will be clear that the clinical position is irreversible and that a natural anticipated and accepted death (section 5.5.2) is inevitable. Such circumstances for example could occur in the urgent acute setting or following the rapid irreversible decline of a known previously stable condition in the community. The conclusion of the clinical team might be that it would not be in the interest of the patient to attempt CPR, because it would not work; a DNACPR decision can then be made. Unless there is very good reason to the contrary, the clinical basis should be discussed with the patient as well as their nominated individual to be involved, and a DNACPR decision with clinical reasoning clearly documented. As outlined in section 4.2, such conversations should be offered to the patient, but where a patient declines them, this should be respected. Asking frequent checking questions like “*Do you wish me to stop this conversation at this point before I continue?*”, may be helpful so that a patient feels more in control, and to avoid lasting harm.

Importantly, while simultaneously reinforcing the fundamental professional requirement not to harm, and that cardiopulmonary resuscitation (CPR) cannot be *demande*d whatever the patient’s wishes may be, the UK Court of Appeal has asserted a human rights presumption for *involvement* in such DNACPR decisions. This *involvement* in a decision is a very different responsibility from the mere *communication* of a finalised one, requiring an open mind; the desire to understand the views, and achieve wherever possible the wishes and preferences of the individual concerned; and consideration of the person’s opinion in the final decision – which then needs to be communicated appropriately.

I must admit, that as I read the policy from the start, and cast my eye over those, I seem to have drawn the wrong conclusion. Ever since I became involved, over a decade ago, the only 'message' I have come across amounts to 'If we clinicians decide that CPR could not work, then we are not going to offer it – and you [patients] cannot force us to attempt it'.

Read with that background, the above sections could be taken to mean 'we will discuss CPR with you if we think it couldn't work – and we'll see if we can persuade you to agree that CPR isn't appropriate – but in the end, whatever you say, we are not going to attempt CPR'.

But section 8.3 changes everything – I wish section 8.3 had been BEFORE those two sections!

As the policy says in 8.3

A patient might insist that future CPR is provided - even when (for clear clinical reasons) the clinical team feel it to be an intervention which cannot provide clinical benefit and will not be successful... In some cases a multi-professional team review might resolve to follow the patient's wishes in an individual case, and to provide CPR, even if it is felt that it will not work or even potentially cause harm.

I will discuss why I think it took these policies so long to arrive at what is said in section 8.3, and a related issue.

Judges – whose words sometimes tend to replace proper subsequent analysis – have not necessarily given rulings on MCA issues, which can easily be translated into a coherent whole. One particular issue, is with '... when CPR would be futile'. Ben Troke, a solicitor, discusses 'futile CPR' in his book, and in a paper I co-authored Alex Ruck-Keene, a barrister, is explicit about what 'futile' means in the context of CPR – the PDF which I pointed to at the start of the appendix contains a link to the paper and also details of Ben Troke's book.

This is what Alex Ruck-Keene wrote in our paper in the Journal of Medical Ethics:

If there is a situation in which CPR would simply not work to restart the heart or breathing, then the paramedics would be under no duty to attempt it, as there is no duty to seek to carry out a futile procedure. However, if it appeared that it might work, then the paramedics are, in England and Wales, governed by the Mental Capacity Act 2005.

Clinicians see 'awful deaths' which result from CPR being attempted on patients who are either very close to death, or who are so 'frail' that a CPR attempt itself would very possibly cause so much damage as to lead to a temporarily-revived patient dying within days or weeks. Very naturally, doctors do not really want to attempt CPR in such situations – and it seems to me, that if a person was both secular and rational, that person would logically refuse CPR in such situations (that is 'a 'theoretical' logical'). However, it is the 'would simply not work to restart the heart or breathing' which falls outside the scope of the MCA - and (from 5.1.2) this calls for an MCA best-interests determination:

Even if CPR might possibly restore circulation and breathing, the benefits of prolonging life must be balanced against the risk of harm, pain and discomfort to the patient. The individual may only survive for minutes or hours.

Best Interests determinations are NOT 'clinical things': anyone who understands section 4 of the MCA can make a best-interests determination. So family and friends can do that, as

can doctors and nurses – anyone who understands both the MCA and enough to properly apply section 4, can form a defensible opinion about what would be in the patient's best interests.

And patients are allowed to make unwise decisions – without getting really nerdy here (because we are talking about applying, not withholding, CPR: that makes it much more complex) basically 'quality of life' should be left to either capacitous patients to consider, or it should be part of a proper best-interests determination. To be blunt: the admirable desire of doctors and nurses to prevent very bad clinical outcomes, which with hindsight patients would not have wanted, is in conflict with the thrust of the MCA to let patients make their own decisions [without that 'future hindsight'].

In reality, the more certain it is that that CPR could not restore life, the less problematic I believe attempting [requested] CPR is. CPR has a poor success-rate at the best of times, and I certainly hope that patients in arrest do not feel CPR being performed. So if CPR is attempted and fails, the patient hasn't really suffered – although relatives who know a loved-one would not have wanted CPR, are often really angry if CPR is attempted. Whereas if relatives knew a loved-one wanted CPR to be attempted, they wouldn't (I assume) be as upset if attempted CPR failed, as they would be if CPR wasn't attempted.

Written by Mike Stone, March 2022

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