

If you don't like it, what can you do about it?

There is currently a 'tranche of' activity, researching CPR/DNACPR and feeding the findings to, using my phrase here, 'the powers that be who might produce some English National Guidance for DNACPR'. I haven't been invited to contribute to this research or feedback – so far as I can see, there isn't an open-invitation for patients, relatives and family-carers to provide feedback via a publicised mechanism – but I am currently doing some 'ear bending'.

I am set on preventing the phrase or sentence 'DNACPR is a medical decision' from appearing within any DNACPR National Guidance which might be created: it is an untrue (certainly for England) and befuddled statement, which people should stop writing. In a sort of general way, we could ask what does DNACPR mean in the phrase (does it mean a decision to not attempt CPR made during a cardiopulmonary arrest, or does it mean documentation intended to influence behaviour during a future-but-anticipated arrest), and what does 'medical decision' mean (does that indicate the decision is made by a medic – and if not that, then what is it indicating?).

In a more specific way, we can easily prove that if cardiopulmonary resuscitation (CPR) might succeed in restarting the patient's heart, then DNACPR is not 'a medical decision': think of an Advance Decision to Refuse Treatment (ADRT) written by the patient and forbidding CPR, or an MCA Best Interests decision that DNACPR is in the patient's best interests made and expressed by a suitably-empowered Welfare Attorney.

Which leaves, CPR decision-making when the clinicians (typically the doctor) believe that for a pre-existing clinical reason attempted CPR could not restart the heart. Does 'DNACPR is a medical decision' make sense, in that situation? The answer is 'no' - I'll show some e-mails I've just exchanged with one of my contacts below, to try and prove why the answer is no.

I will mention, that I have read quite a lot of discussion of the situation of a patient 'insisting on' attempted CPR, when the clinicians believe that CPR could not restart the heart, in guidance/policy/protocols about CPR. But I have NEVER seen a discussion of the situation which involves the presence of a family carer who could attempt CPR. The policies I've read, tend to be a bit 'muddy' because they seem to conflate 'CPR could definitely not restart the heart' with 'CPR has only got a tiny chance of restarting the heart', and they also seem to struggle with the resolution.

I have recently suggested a different approach to 'CPR documents' in my piece at:

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Mikes-Cheeky-Blog-a-proposal-for-a-different-type-of-DNACPR-document./1142/>

One of the examples I used, is the one I've just been discussing with my contact. I will show the e-mails we exchanged next. I'll use a different font, and I will show my e-mails in plain text and my contact's e-mails in italics. One of my local supermarkets has a got a 'too good to waste' section, and I'm publishing this e-mail discussion because it is too good to be wasted. I cannot see, that we are wrong about this – there isn't any way of resolving that 'dispute'.

And, I believe the RCGP should also be unhappy if 'DNACPR is a medical decision' is not removed from all guidance/policy about CPR/DNACPR – that surely implies that a GP can somehow prevent CPR from being attempted, an expectation which in reality cannot be fulfilled by GPs.

My text yesterday evening, was for your opinion on this - is it, as I think, 'not resolvable by 'legal means'?"

In my recent piece about a different version of DNACPR documents – when everyone recorded what the individual would do if the patient arrested now – I included the example of a situation of disagreement:

Example 1

The patient is at home, and his capacity is not being questioned.

I am the patient, and I want CPR to be attempted, irrespective of why my heart stops beating James Smith *J Smith*

I am the patient's GP, and I do not believe that attempted CPR could restart Mr Smith's heart – so I will not be attempting CPR Kenneth Jones *K Jones*

I am the patient's son, and a live-with family-carer, and I will be attempting CPR because my dad has asked me to attempt CPR. Bill Smith
Bill Smith

Interestingly, I suspect that situation is 'an end point'. I can't see that any legal mechanism exists by which it could be resolved. I will point out: on my suggested alternative version of CPR document, at least the existence of such a situation would be recorded – which isn't true on the abysmal main ReSPECT form.

Hi Mike:

I suspect you know what I'm going to say but here goes anyway.

1 nobody can 'fetter clinical discretion' as the cliché goes; so nobody can make a medical professional give any treatment he/she regards as futile or harmful, in a holistic way, to a patient. In practice, 'futile' is more fuzzy than 'harmful': a diplomatic GP or paramedic might think, this is futile, e.g. it won't work, but the family are kicking up a storm to get CPR, and the stubborn patient always wanted it, so I'll give it a fair go (but not, probably, to the point where I burst a blood vessel...). This contrasts with the patient/relative demanding some novel treatment they've read about in the media, which is not authorised for use in this country, and which has an unacceptable profile of side effects.

2 The 'stubborn' patient, and his relative, are of course not bound by the MCA in a legal way. If either the patient with capacity takes, or the relative with capacity gives, some treatment such as CPR which will not of itself breach criminal law - so the relative isn't giving a poison or even assisting a suicide - then there is not only no role for the Court of Protection, there is no role for the criminal courts either. After all, the relative is, as you explain, doing what he believes is in the best interests of his father; the patient, too, when capacitated to take this decision was also of the fixed opinion that CPR might help him. So the relatives administers CPR: it either works or it doesn't but

(a) the relative has the comfort of knowing he did his best to comply with Dad's wishes,

(b) he still thinks he was right to try, and since 'never say never while life persists' is a reasonable ethical position; and

(c) if by a long-shot the CPR works and gives the patient another reasonable even if short period of tolerable life, they both will think it worth it, and also the medic/paramedic will never hear the end of it. And what fun the relative will have, telling this saga!

3 All in all, you have no need to bring in the poor old Court of Protection, and it doesn't matter at all that you can't. There are other routes, though they will not often I suspect be felt as appropriate or worthwhile - complaints procedures, Ombudsmen, and criminal law; possibly even the High Court Family Division.

What I was really wondering, re my scenario, is probably 'how many nurses, or police officers, incorrectly believe that the GP has got some sort of authority or legal-remedy to which would resolve that situation'? I'd also been wondering, if it might be possible to apply/argue-from the rulings of cases which could get to the CoP - so, in essence a comparable situation but with an incapacitous patient - to my scenario. And I decided that can't be done, because judges always say 'in this case' and, invariably the pro-CPR is given the chance to try and hunt-down a doctor who says 'I think CPR might work'.

Why did you mention complaints procedures, etc? I'm not suggesting that there should be a complaint about anyone's position or behaviour in that scenario - but, it is [I belatedly realised, only yesterday!] a concise way of debunking this 'CPR/DNACPR decisions eventually devolve to clinicians' nonsense.

re complaints: people in my experience are quick to complain about medical professionals, who, therefore, may be tempted to act in a way that might stave off such complaints - i.e., they do what the noisy relatives / stubborn patients want them to do even if they wouldn't if considering only medical best interests.

Yes this truly isn't one for the courts: maybe for mandatory MCA training, which I've lobbied for since before Noah's flood.

I am not disagreeing with what you've written - although I bet there hasn't been any robust-research into 'do clinicians behave so as to stave off complaints'.

They aren't (Mr J Charles explained this, although more in the in-court discussion than in his ruling, that 'medical best interests' isn't the same as MCA best interests, and it is MCA best interests which he had to apply (the Kitzingers got permission to observe/publish during Briggs)).

Interestingly, I don't think either of us can entirely predict 'how the other will argue the case'. I think we know that almost always we will agree about 'the outcome', but the different ways we get there always fascinate me.

For example, your analysis of 'futile'. I don't like 'CPR would be futile'. I want 'If CPR could not restart the heart, then doctors are not obliged to offer CPR'. But 'not obliged to' isn't the same as 'cannot'. Then I would introduce much the same reasoning as yours, as to why perhaps CPR should be attempted. I would point to an argument I put in a BMA rapid response years ago: what is the relative expected to do, in the scenario? Even if you think CPR wouldn't be successful, if your dad asks 'are you going to try?' are you expected to say 'no' and fall-out with your dying parent? And if you say 'yes, I'll try CPR and/or call 999' are you then expected to not do that - are you expected 'to live with having lied to your dying father'?

Then, I would move on to 'keep everything identical - but change the GP'. It doesn't seem satisfactory, that whether you are offered CPR depends on the whim of your GP: surely we need consistency - either all patients in that situation are offered CPR, or none are?

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Mikes-Cheeky-Blog-I-believe-that-CPR-should-be-attempted-if-a-mentally-capable-patient-had-asked-for-CPR-to-be-attempted/1051/>

A doctor I talk to has also got a thing about the very-limited attention given to the MCA when medical students are being taught - from memory, it is 'an afternoon' and the doctor has been lobbying, unsuccessfully, for more like one or two weeks. The doctor even suggested that I might contact the BMA etc about that - I said 'if they won't listen to you, they aren't going to listen to me!'.

I am wondering, if 'national guidance around DNACPR' - which looks to be what is being considered - is the wrong approach at the moment. I'm wondering, whether it would be better to have a few senior professionals (such as a hospital doctor, a GP, a social worker and a 999 paramedic) paid to be open and receptive to EVERYONE's feedback about CPR/DNACPR on perhaps a one-day-per-month basis. Of course, the public would have to be given details of how to contact those individuals, as would professionals. Then that group of professionals who had been listening and I'd hope thinking, would feed into policy development.

I honestly worry, that we are about to be lumbered, with some 'English guidance/policy' about CPR/DNACPR, which over-considers the problems from the doctors' perspective, inadequately considers the situation/problems from the relatives' perspective, and at the upper-levels of policy consideration, will have been 'approved' by people who simply do not understand the complexity of EoL/MCA/CPR. And to boot, which will utterly collapse at the coal-face of EoL-at-Home, when challenged by legally-clued-up family-carers.

A couple of points, to close.

Doctors like to apply Medical Ethics and the somewhat simpler concept of Best Clinical Outcome to their own decision-making. Suppose in the situation above, the GP and the family-carer are both present when the patient arrests. The GP doesn't believe that attempted CPR will work [and the presence of the family-carer cannot alter that belief], but the GP knows the family-carer will attempt CPR: using the argument that 'if CPR is being attempted anyway, surely it should be attempted by the person most-competent to perform CPR', wouldn't Medical Ethics and Best Clinical Outcome lead the GP to say 'Out of the way - if CPR is being attempted, I'm probably better at it than you are, so let me do it!'.

My second point, is that my proposed CPR document has no problem with the situation I've described – everyone involved, simply records what they want or what they would do if the arrest happened now:

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I am the patient's GP, and I do not believe that attempted CPR could restart Mr Smith's heart – so I will not be attempting CPR Kenneth Jones *K Jones*

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I cannot work out, how the main ReSPECT form would, in the context of CPR/DNACPR, document the situation I have outlined. The ReSPECT form claims to be about 'realistic interventions' (section 4) so perhaps a ReSPECT form cannot exist, if the patient has insisted that 'I have been told that CPR has no chance of restarting my heart, but even so I want CPR to be attempted if my heart stops beating' is written in section 3. If the form can be created, with that written in section 3, then I'm baffled by how the clinician would complete section 6. And I can't see where the information that a family-carer has indicated that he/she would attempt CPR, appears on the ReSPECT form. However, I am sure that we cannot legitimately ignore, within the context of Advance Care Planning, the knowledge that the patient wants CPR to be attempted even if the clinicians believe it could not restart the heart, and the knowledge that a family-carer has indicated that she/he intends to attempt CPR as requested by their loved-one – and as it happens, I think we should change behaviour in this situation as I've argued here:

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Mikes-Cheeky-Blog-I-believe-that-CPR-should-be-attempted-if-a-mentally-capable-patient-had-asked-for-CPR-to-be-attempted/1051/>

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