What can be said about CPR/DNACPR?

When recently I posted on X/Twitter that I believe the sentence/phrase 'DNACPR is a medical decision' should be thrown away, and never written in 'official' guidance of any sort, someone who trains nurses and doctors asked what could be said? I've been posting my suggestions about what could be said, one-after-the-other, on X/Twitter. It might be useful – to make people have a think, even if they don't believe I've got these right – for me to show what I think can correctly be said, **for England**, here.

1) Doctors and nurses who are involved during a cardiopulmonary arrest, are required to either attempt or withhold cardiopulmonary resuscitation (CPR), and they NEED to have a legally-defensible rationale for whichever choice (attempting or withholding CPR) they make.

2) It is unreasonable, to 'demand a complete understanding of the situation': this is true if you are a clinician or a relative or friend – nobody will have anything like a complete understanding of everything, and the clinicians and those 'close to the patient' will each tend to have a better understanding of particular things.

3) Family-carers and relatives, when a loved-one seems to have arrested at home, typically will NOT EVEN REQUIRE a legal defence whatever they do (attempt/support CPR, or withhold CPR). But 'family-carers' especially will consider themselves to be 'involved and not simply passive observers' and therefore will normally 'be trying to do what is best for their loved-one'.

4) If a capacitous patient is refusing, or a valid advance decision (ADRT) is forbidding, CPR for the situation of the arrest, then CPR should not be attempted.

5) Mental Capacity Act (MCA) best interests cannot be the justification for not offering CPR, but an MCA best-interests determination can be the justification for withholding CPR which is being offered.

6) The concept of medical best interests cannot be determinative for whether an available treatment is applied or withheld: either informed consent or MCA best interests determine if an intervention takes place. The concept of medical best interests might contribute to the processes of informed consent or MCA best-interests determination.

7) If it is clear that CPR could not restart the heart and breathing, then CPR need not be offered.

If there is a possibility that CPR might restart the heart and breathing, then the three possible reasons for not attempting CPR are:

a) a capacitous patient’s refusal of CPR

b) an MCA best-interests determination that DNACPR is appropriate

c) [in theory – this reason never seems to be discussed or given for DNACPR] if CPR were to be clinically-successful, the costs of necessary aftercare would be too burdensome on the NHS

8) For a subset of best-interests situations, CPR should not be attempted if it is understood to a sufficient degree of certainty that the patient, if ‘[conceptually] somehow aware of the situation and if the patient could decide’, would refuse CPR. There is no reason to assume that some relatives and friends will not be aware of this.

9) Relatives and friends should not be asked ‘Do you want us to attempt CPR on dad?’. The correct question is ‘Would dad want us to attempt CPR if his heart stops?’.

Tip: if the reply is ‘In my opinion, it would be in my dad’s best-interests for CPR to be attempted’ then assume the person you are talking to is probably aware of the MCA.

10) In principle, decision-making should be happening DURING an arrest. But in reality, the necessity of starting CPR immediately if CPR is to be performed, makes it ‘impossible in practice’ to make decisions during an arrest. There are legal and logical reasons, which mean that making a DNACPR decision BEFORE an arrest occurs, is deeply problematic.

The ‘logical compromise’ is to combine ‘the decision was made in advance’ with ‘and I have been sufficiently present to be confident that nothing relevant has changed since the decision was made’.

This is VERY DIFFICULT TO RESOLVE!

I have concluded my list – there is enough for people to be thinking about there – and I will move on to describe two factors which I believe are hugely relevant for DNACPR, but which so far as I can see are largely unaddressed.

A friend of mine, always gets very annoyed [because of personal experience] with comments in academic papers or guidance that ‘clinicians find conversations about CPR/DNACPR with patients and relatives very difficult’. My friend tends to see that as ‘pushing the blame for the problems doctors have with the conversations onto patients and relatives’ when the conversations are legally necessary under our law: my friend says ‘If they struggle to hold the conversations, then doctors need to be trained better! Stop blaming patients and relatives, and stop apparently trying to wriggle-out of holding difficult conversations about CPR/DNACPR!’. My friend sees doctors as being ‘paternalistic’ to an unacceptable extent, in some situations.

As it happens, I sent an e-mail to my friend a couple of days ago, and I included the following in my e-mail:

I've got mixed views on the 'paternalism' thing.

*I definitely think that a lot of doctors are tempted to be 'paternalistic'. Despite the fact that our law has removed medical paternalism. But in part, that surely stems from the fact **that they see the consequences** of patients who seem to have made 'the wrong decision'. Lots of well-intentioned doctors, clearly struggle with the fact that Informed Consent allows patients to make downright-stupid decisions, while the doctors 'wish to do no harm'. Loosely, some doctors must be attracted to not discussing CPR with patients, because they are unhappy that the patient might ask for CPR and then it would have to be attempted, with in most cases 'pretty dire outcomes for the patient'.*

I honestly think, that we will never get to where we need to be re CPR/DNACPR, until many more patients and relatives understand the clinical consequences of attempted CPR better – so we need layfolks to be aware of those ‘dire outcomes for the patient’ which doctors see, and we don’t. These days, TV shows such as Casualty do have more examples of attempted CPR failing to restart the patients heart. But we – the public – are still ‘seeing’ on TV, two outcomes of CPR: either ‘it works’ or else it fails to keep the patient alive. What **we don’t see**, are CPR attempts which break ribs and puncture lungs and other internal organs, and temporarily restore the patient to life, but in such a battered clinical condition that death after a few days of life, of uncertain consciousness and perhaps significant levels of distress and discomfort, is inevitable whatever the clinicians try to do.

Rationally, in almost all situations, a willingness to accept attempted CPR amounts to the triumph of optimism and hope over cold hard reason. I’m not suggesting that patients shouldn’t have the right to make that choice, and to plump for optimism in the context of CPR – but we need to create a public which is aware of the actual consequences of

CPR, so we need doctors to have honest conversations about CPR with patients and relatives.

Written by Mike Stone September 2023

X/Twitter @MikeStone2_EoL