

CPR: Secrets, Untruths and Unspoken Truths

I was told by a senior paramedic, that the first thing a 999 paramedic should do is to ask 'Why was I called?'. I simply cannot believe, that many family-carers reply 'So that you can ignore what I tell you'.

See <https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Clinicians-and-Relatives-Consensus-Uncertainty-Emergency-and-Trust-a-continuation-from-a-Journal-of-Medical-Ethics-paper/1112/>

Introduction

It is now about 15 years since I became 'involved with' End-of-Life (EoL), the Mental Capacity Act 2005/7 (MCA) and Cardiopulmonary Resuscitation (CPR). Right from the start, I was annoyed by what I discovered clinicians were writing within CPR guidance. I am still annoyed now, although the focus of my vexation is now the ReSPECT form.

'We' – patients and relatives – are being told things about 'our role during CPR decision-making' which are not true, and are also biased against our situation as family-carers. Doubtless some would argue that 'It isn't bias against family-carers, it is the best way to balance many competing factors' but that isn't how I see it: the 'balance' which clinicians currently see as reasonable, impedes the best-achievement of the objectives of the MCA, and it doesn't respect family-carers. Furthermore, current documents such as the ReSPECT form 'impart to their readers' a flawed understanding of the legal situation around, in particular, CPR decision-making. *Something that deeply vexes me, is that this situation would surely have to change, and very quickly, if there was a widespread understanding of the law around CPR among patients and family-carers.*

There isn't a widespread understanding of the law around CPR among patients and relatives, so far as I can tell. And there isn't widespread understanding of 'dying' either, although Dr Kathryn Mannix's well-received book 'With the End in Mind' is a recent attempt to demystify 'dying and death' for the general public. Most of the writing about the decision-making around CPR is by

clinicians and lawyers, and I believe it would be very helpful if more patients and family-carers also wrote about it: although I'm not optimistic that this will happen.

The situation which current guidance is most-obviously 'biased against', is that of a cardiopulmonary arrest in the patient's home, especially if the patient/loved-one is mentally-capable until the arrest occurs, and when the guidance is read from the perspective of a family-carer who is present. This is a section from some General Medical Council (GMC) guidance:

Patients who lack capacity

139 If a patient lacks capacity to make a decision about future CPR, you must consult any legal proxy who has authority to make the decision for the patient unless it is not practicable or appropriate to do so. If there is no legal proxy with relevant authority, you must discuss the issue with those close to the patient and with the healthcare team. You must make all reasonable efforts to have these consultations or discussions at the earliest practicable opportunity and they should be approached with sensitivity. In your consultations or discussions, you must follow the decision-making model in paragraph 16. In particular, you should be clear about the role that others are being asked to take in the decision-making process. If they do not have legal authority to make the decision, you should be clear that their role is to advise you and the healthcare team about the patient's wishes and preferences to inform the decision about whether attempting CPR would be of overall benefit to the patient. You must not give them the impression that it is their responsibility to decide whether CPR will be of overall benefit to the patient, or that they are being asked to decide whether or not CPR will be attempted. You should provide any legal proxy and those close to the patient, with the same information about the nature of CPR and the burdens and risks for the patient as explained in paragraph 137.

My problem with this, is that it **seems to imply** that relatives and friends cannot form 'valid' (by valid, I mean compliant with MCA section 4(9)) positions as to whether or not it would be in the patient's MCA Best Interests for CPR to be attempted. It is true, that from the doctor's perspective the family and friends (and 'those close to the patient' is, in fact, probably the conceptually-

clearest phrase) are providing information which the doctor then considers. But, it is a logical necessity that family and friends who understand the MCA, will often be capable of arriving at defensible best-interests positions as a consequence of the discussions involving the clinicians and those close to the patient. **Unspoken Truth:** especially during ‘an emergency’, and particularly for CPR, it is easier to explain the clinical situation than to explain ‘the patient’s individuality’ (‘the patient’s individuality’ often amounts to ‘if the patient could consent to or refuse attempted CPR in this situation, what would the patient decide?’). And it seems to me, that there is an ordering – MCA Best Interests is similar to Informed Consent, in that the clinical situation needs to be understood first, and only then can we try to work out what the patient would have decided.

That GMC guidance is also dodgy in saying ‘you must consult any legal proxy who has authority to make the decision for the patient’, because if you read section 4 of the MCA, and if there is a legal proxy with [section 6(6)] authority over the decision, then it is the legal proxy who must consult the doctor.

I will point out that it seems to be the ambition of the Resuscitation Council UK, to reach a situation when almost everyone is capable of performing CPR. *So, if a loved-one appears to have had a cardiopulmonary arrest at home, when only a family-carer is present, surely ‘a decision about CPR’ can only be made by the family-carer: **there is nobody else able to make a decision, because nobody else is there.*** It is easier to see this, if the family-carer could him/herself attempt CPR, but in fact it doesn’t matter and even if the family-carer cannot perform CPR, the family-carer can still apply the MCA’s concepts.

I believe the MCA’s ethos should guide the behaviour of both clinicians and family-carers during EoL, and that this can only happen if clinicians and family-carers behave as ‘us & us’ and not as ‘us & them’. It would help if ‘those close to the patient’ understood that **they are experts** – even if they don’t realise that they are experts, or do not wish to be regarded as experts. And, it would help if clinicians explicitly described those close to the patient as experts. An MCA best-interests determination – at least, what I describe as a ‘genuine’ MCA best-interests determination – requires both clinical expertise (treatment options and outcomes) and an ‘understanding of the patient as an individual’. The person’s close family and friends are experts ‘in the person as an individual’ and the clinicians are the experts in the clinical situation. Input from both types of expert, and also an understanding of the MCA – and clearly it is

possible for both clinicians and layfolk to understand the MCA – is necessary in order to arrive at an MCA best-interests determination.

Almost-a-Secret: doctors do NOT make MCA best-interests decisions. Family-carers do NOT make MCA best-interests decisions. Only Court Deputies, Welfare Attorneys and Judges make MCA best-interests **decisions** – everyone else can only make MCA best-interests **determinations**. This is both unnecessary in my opinion, and deeply vexing: it makes it almost impossible to write both lucidly and correctly about the MCA.

I used to analyse who would be better-placed to make a best-interests determination about CPR, if a 999 Paramedic and a family-carer were standing over a patient/loved-one who had arrested. It seems to me, that provided the family-carer is ‘calm’ then in principle the family-carer is the person who could perhaps understand ‘what would the patient have decided’. However, while I still believe that analysis -

Unspoken Truth: despite what the MCA’s description of a best-interests determination might seem to require, it is in reality almost never possible to apply MCA best interests during a cardiopulmonary arrest – **you need to have already decided what to do before the person arrested.**

I have suggested an alternative approach to ‘DNACPR forms’, which I discuss in Appendix 3 – I also point to some of my earlier writings about the interactions between family-carers and 999 paramedics [in the context of CPR] in Appendix 3.

Surprisingly Little Understood: CPR is a damaging treatment. It doesn’t have a high success rate, often even if it restores life it doesn’t leave the patient in as good a clinical situation as was the situation before the arrest, and especially if chest compressions are performed on someone who is elderly and/or ‘frail’ then CPR itself can cause so much clinical damage (broken ribs, punctured lungs, etc) that if CPR was performed on healthy-but-frail individuals (i.e. *if we imagine* CPR being attempted on a person whose heart had not stopped beating) some of them would die as a result of the CPR itself. The depictions of CPR in TV medical dramas, while these days showing the ‘it didn’t restart the heart outcome’ more often than they used to, are much ‘gentler’ than the reality. A doctor during a discussion on Twitter said ‘You don’t hear the crunchy noises as bones break on TV’. Attempted CPR, if we are thinking of the chest compressions, potentially amounts to Grievous Bodily Harm.

And even if CPR itself wasn't physically damaging, if your heart has stopped and no oxygenated-blood is reaching your brain, within 2 or 3 minutes your brain will start 'dying' – irreversible damage to your brain will start to accumulate. Eventually CPR would not be able to restart the heart, but there is a period when CPR might restart your heart, but you would have serious and permanent brain-damage to live with.

CPR is also unusual, in that the clinical outcome if life is restored, cannot usually (see note) be predicted even if a clinician is present: so you can be adequately-informed of the clinical outcome should you arrest, before the arrest happens (and the information amounts to 'At best your clinical situation would be the same as it was before you arrested, at worst you would be alive but permanently comatose or living with very severe brain-damage, and it can be anywhere between those two situations').

Note: There is the odd exceptional situation, such as if the heart has been deliberately stopped during a surgical operation, when attempts to restart the heart should be much more successful.

For a discussion of 'CPR is potentially an assault' and why people are not usually charged with assault when they attempt CPR, see Appendix 2.

[surely an] Unspoken Truth: if your parent or partner has decided to refuse attempted CPR, then surely he/she tells you 'I don't want CPR – don't let 999 Paramedics attempt CPR'. I can't believe that anyone says 'I don't want CPR – but I'm happy for 999 Paramedics to start CPR, while you persuade them to stop'. That would be similar to someone saying 'I don't want to be punched in the face – well, being punched in the face a few times would be okay, if the punching then stopped'.

Some Analysis of the ReSPECT form (version 3.0)

The ReSPECT form is not only vexing if you cast an MCA-aware eye over it, but it isn't even internally coherent. In section 1 we can read:

'The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations.'

I believe I, or any other reader of a ReSPECT form, can expect that those sentences will be true, and also 'explained'. The first sentence is not true – there is a box in section 6 which can be ticked to indicate 'This person does not have the mental capacity, even with support, to participate in making these recommendations'. I assume that if the patient is mentally capable, then if the patient and the clinician do not reach agreement, there cannot be a ReSPECT form: if the form 'is a clinical record of agreed recommendations' and there isn't agreement, presumably a ReSPECT form cannot be created (I am not sure if that is stated explicitly by ReSPECT, nor am I convinced that ReSPECT forms are never created if a capacitous patient has forbidden the creation of the form). Nor is it clear to me 'who has to agree' to the creation of the form, if the patient cannot him/herself agree (for example if the patient is comatose).

The first tick-box in section 6 reads:

'This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.'

How did we get from 'agreed' at the start of the form, to 'participation' and 'involvement'?

During a bank robbery, the bank's staff, the bank's customers, the bank robbers and police officers can all be 'involved' - but in very different ways.

From the perspective of the MCA – so in England and Wales – much of the ReSPECT form seems dubious. To start with, it isn't clear to me [and I've been thinking about MCA best interests for about 15 years] exactly how 'a recommendation from a clinician' fits into MCA section 4 [which is the section of the MCA that 'explains' how best-interests determinations must be made]. Section 3 of the ReSPECT form (the 'What matters to me' section) looks like

what is often called ‘an advance statement’. Although the MCA doesn’t mention ‘advance statements’ - what the MCA says is (section 4(6)):

4(6) He must consider, so far as is reasonably ascertainable—

- (a) the person’s past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
- (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
- (c) the other factors that he would be likely to consider if he were able to do so.

Section 4(6)(a) says ‘and, in particular, any relevant written statement made by him when he had capacity’. ***The usual ‘confirmation’ that a written statement was made by a person, is that the person signs it – so why does ReSPECT not allow a capacitous person to complete section 3 of the form her/himself, and to then sign that section?***

Similarly, if the person isn’t capacitous when the ReSPECT form is being created, and there is a court deputy or welfare attorney involved, why doesn’t the form allow the attorney or deputy to record and sign any ‘recommendations’ about things which would be decisions for the attorney or deputy to make, if at the future time when the form was being read the attorney or deputy was present?

Unspoken Truth: doctors who work in end-of-life care, will tell you that listening to the patient is important – so if a family-carer is present and can listen, there are no clinicians present so no clinicians could have listened, and it would be unreasonable to believe ‘a clinician should have been there to listen’, it is **deeply offensive** to have ‘a mindset’ which seems to amount to ‘I (an emergency clinician) will not believe you (a relative) because I wasn’t there to hear it myself’.

I’ll leave the ReSPECT form now, with a closing comment: I dislike the presentation of ‘recommendations’ and *I believe these forms should contain and present information instead of recommendations.*

Unspoken Truth: it is biased against family-carers during EoL-at-Home for clinicians such as 999 Paramedics to put their emphasis on written records – because family-carers use conversations with their loved-one, the GP, nurses etc. We [family-carers] don't spend our time writing things down, and we acquire our understanding by conversations, listening and observation. This recourse to written records, is fairly-obviously a necessity if a clinician is involved only periodically with a multitude of patients (think of the doctor who is covering a hundred patients in a hospital, at 2am on a Sunday) – but family-carers are only involved with one person/patient and tend to be present with that person/patient for a much-greater proportion of the time (in some cases, if the family-carer is living with the person/patient, the family-carer will be present almost 24/7).

Untruth: or perhaps an unspoken truth. It isn't possible, to have certainty about all manner of things during an emergency, because there isn't the time to prove things. If emergency clinicians, such as 999 Paramedics, expect/require family-carers to 'prove that something not-yet-recorded' did happen, then we family-carers are [very offensively] being accused of nefariousness when it is impossible for us to prove our honesty, and furthermore objectives such as 'respecting patient autonomy' are often defeated as a consequence.

Surprisingly Little Understood: whereas lawyers often emphasise things such as 'an ADRT refusing a life-sustaining treatment must be written to be valid', and while lawyers [because of their situation as lawyers] are unlikely to agree with me about this, if we want to apply the ethos of the MCA during 'emergencies', then we almost certainly need to apply its Principles in combination with 'how certain we are of things'. It is absolutely mad to believe that if a hospital doctor has been discussing CPR with a patient for 30 minutes, during which the patient has made it clear that if he/she should arrest for any reason at all then he/she is refusing CPR, that somehow the doctor has a best-interests determination to make if the patient arrests as the doctor is walking away from the patient's bedside. *If the doctor has just said 'Okay – I'll go and get the paperwork for an ADRT and a DNACPR' and the patient's heart stops as the doctor turns to go and get the paperwork, then the documentation does not make the doctor any more certain that the patient is refusing CPR!*

Insufficiently Spoken Truth: *As I've just explained, it is presence – being with the patient – which enables certainty:* presence enables conversation, discussion and observation – and you can put questions to a patient, but you cannot put questions to a document. If I'm sharing a home with someone who has created an Advance Decision (ADRT) which refuses CPR, then I 'know' it hasn't been retracted because 'if he[/she] had decided to retract the ADRT, he[/she] would have told me'.

The Change we need – in my opinion

I come across ideas such as co-creation and co-design, and cognitive authority, and I also come across things such as Martha's Rule – an AI description of Martha's rule being:

'Martha's Rule is a patient safety initiative designed to empower patients and their families to seek an urgent review from a critical care outreach team if they are concerned about a patient's deteriorating condition and feel their concerns are not being addressed by the current care team. It provides a formal escalation route for patients, families, and carers to ensure their concerns are heard and acted upon, promoting transparency and collaboration in healthcare.'

A lot of the complaints about the NHS do seem to come down to 'we [patients/relatives] were not listened to'.

My issue with end-of-life and the MCA, is that the clinicians seem to have the desire for it to be 'We [clinicians] listen to you [family-carers and relatives] and then we [clinicians] decide.'. But for EoL-at-Home, neither the law nor logic suggests that can be true: we need to change to a less hierarchical 'model' and description. Which accepts that family-carers will sometimes be faced with decisions which only they can make.

Until that changes, and with great reluctance, I am being forced to write things such as my conclusion in the PDF you can download from my piece at:

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/NHS-Planning-Ahead-seems-to-be-excluding-family-carers-and-I-am-very-annoyed-by-this-and-I-want-things-to-change./1139/>

I'll reproduce what I wrote in that PDF:

How Can We Change Things?

The 'we' means patients, family-carers, relatives and close friends. And, unfortunately, it seems that 'they' – 'they' meaning clinicians and the system – will not willingly change their attitude, so we will probably need to be much more assertive. **We need to challenge things which are wrong.**

I'll give a few examples.

If a husband and father is comatose in hospital, and his family are summoned to the hospital to discuss what should happen next, then if a doctor says 'You need to help me to work out what is in his best interests' we should forcefully counter with 'Sorry – we all need to discuss things, so that we can each work out what is in his best interests'.

If a ReSPECT form is being completed for a capacitous patient, the patient should insist on completing and then signing section 3 him/herself. And if the patient is incapacitous, and a welfare attorney or court deputy would have legal authority over a decision made 'in the now', the attorney or deputy should challenge the signatures on section 4 of the form – pointing out 'if this looks like an anticipatory best-interests recommendation, then I should be making and signing that, if it would be my decision to make if the event happened now'.

Family-carers in particular, should be aware of the legal situation of relatives during EoL - <https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Championsforum/DNACPR-at-Home-and-a-Twitter-thread-what-is-the-legal-situation-forrelatives/1110/> - and if it is suggested they have done something wrong, we should ask 'which law are you suggesting I have broken?'.

Now, TO BE CRYSTAL CLEAR. I am NOT trying to set relatives and clinicians at war with each other, during end-of-life. I want clinicians and relatives to be valuing and respecting what each is 'bringing to the table', **and to properly work together** in supporting dying loved-ones/patients. But EoL-at-Home in particular, can become extremely complex – and it is intolerable, to add to the distress of a loved-one's dying and death, an attitude of 'we don't trust you, and we are under-valuing your input and role'. So if 'we' need to challenge

‘them’, in order to force a change in professional mindsets from ‘us & them’ to ‘us & us’, then that is what we need to do: sadly!

Extract from the PDF ends.

Doctors seem to have come to terms with the face-to-face aspect of patient autonomy during Informed Consent/Considered Refusal, although they are still struggling with the indirect aspects of patient autonomy (that patients can create perfectly legally-valid Advance Decisions without involving a clinician, etc). But as for the position of relatives and family-carers when the patient/loved-one lacks the mental capacity to make his or her own decisions, doctors and their medical bodies seem to still be struggling to accept that family-carers have a degree of autonomy and are absolutely integral to the situation [and to Future Care Planning].

Written by Mike Stone, July 2025

APPENDIX 1: A Little about Best Interests and Planning Ahead

I’ve written a lengthy piece about MCA Best Interests

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/I-think-we-need-a-different-way-of-explaining-and-teaching-the-Mental-Capacity-Act-MCA/1114/>

but I wish to emphasise here that **for life-sustaining interventions, making a best-interests determination is awful!**

It is one thing to support someone’s autonomy – and quite another to in effect make a decision on their behalf. It is also far from obvious, that doctors make better MCA best-interests determinations than family and friends: in particular doctors seem to quite often conflate ‘medical best interests’ with MCA best interests.

Why, then, does the medical profession seem so set on asserting that in the absence of an empowered legal proxy, the patient’s family and friends merely provide information – why are family and friends not facilitated to make their own determinations of what would be in the patient/loved-one’s best interests.

If that was done, then ideally everyone – clinicians and family and friends – would [individually] arrive at the same best-interests determination: **and if everyone has arrived at the same best-interests position, then everyone can feel much more certain that the best-achievable best-interests determination has been arrived at.**

The guidance for doctors, tells them that if they believe an attorney or deputy has expressed an unreasonable best-interests decision, the doctors should discuss it with the legal proxy, and perhaps then take the issue to court. This is interesting, in that it isn't obvious how the doctor would form a best-interests position in some situations. Suppose that Fred is involved in a car crash, and is comatose in hospital. Jim and Jenny go to the hospital, and prove that they are Fred's welfare attorneys with section 6(6) authority over all medical interventions. In theory – and perhaps in practice – Jim and Jenny can satisfy the requirements imposed by section 4 of the MCA by:

- 1) talking to the hospital doctors to get all of the clinical information about treatment options and prognoses, etc, then
- 2) going away and talking to Fred's family and friends, to get their views about what Fred would decide if Fred could somehow make the decision himself, then
- 3) making a best-interests decision and then returning to the hospital to tell the doctors what the decision is.

Without any understanding of 2), how can the hospital doctors arrive at their own best-interests position? Note that nobody disagrees that the decision is for Jim and Jenny to make.

It is possible – doctors are busy! - that the doctors would be happy with that. But I think some discussion about 2) between Jim and Jenny and the clinicians, would make the clinicians feel 'easier' or 'reassured'. I will point out, that I think Jim and Jenny could say to the hospital doctors 'We should only breach Fred's privacy to the minimum extent necessary – and while we need to explain Fred's clinical situation to his family and friends or else we can't get useful

input from them, it doesn't seem necessary for us to reveal the content of our discussions with Fred's family and friends to you'.

And: **that doesn't seem very 'co-operative'.**

Change the scenario to this:

Suppose that Fred is involved in a car crash, and is comatose in hospital. After a few days the hospital doctors ask Fred's wife if she and her two adult children could come to the hospital to discuss what should happen next. This is clearly an MCA best-interests meeting. Isn't it best, to explain to the family what the objective of a best-interests determination is

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/MCA-Best-Interests-compressed-to-a-single-sentence-an-ansatz/972/>

and then for the clinicians and the family to all get their heads together, individually form positions as to what would be in Fred's best interests, ***and then if everyone has arrived at the same best-interests position to adopt that position without asserting that any particular individual made it?***

That is in my opinion the best way to both achieve a good best-interests position, and to satisfy yourself that a good best-interests position has been reached: if many minds agree, and no minds disagree, then that 'inspires confidence'. **However:** it is still better to follow the patient's own self-determination. So what the NHS should be doing, is to promote the creation of Advance Decisions which forbid CPR, instead of emphasising things such as the ReSPECT form which involve the making of best-interests determinations. The problem, certainly so far as I can 'perceive it', seems to be that the NHS is unhappy that ADRTs are completely patient-controlled and can be created, modified and retracted entirely without the involvement of any clinicians, and the NHS is deeply wedded-to documentation which is signed by doctors – and ***legally only the ADRT can forbid CPR, the documents controlled by and signed by doctors cannot do that.***

The NHS has correctly identified that 'planning ahead' is helpful, and it definitely is in the context of end-of-life. Historically, and to a rather disturbing extent still, the approach has involved something that clinicians call Advance

Care Planning (ACP): and I said it is ‘disturbing’ that there is still an emphasis on ACP because Wales has developed a superior concept called Future Care Planning (FCP) which everyone should quickly adopt. I will not explain why FCP is better than ACP, because Taubert and Bounds have explained it very clearly in their paper at:

<https://spcare.bmj.com/content/14/e1/e608>

I was intensely annoyed a few years ago, to come across some ‘NHS guidance’ about ACP, for exactly the reasons I have already laid out – the guidance states that ACP is created between the patient and the clinicians, while it is blindingly obvious that during EoL-at-Home if you want coherent forward planning, the planning **must involve** family-carers and others who are sharing a home with the patient/loved-one. I will point at two pieces I’ve written about this:

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Comments-on-some-NHS-Advance-Care-Planning-Guidance-about-the-principles-of-ACP/1120/>

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/NHS-Planning-Ahead-seems-to-be-excluding-family-carers-and-I-am-very-annoyed-by-this-and-I-want-things-to-change./1139/>

Putting aside ‘nerdy arguments’ about the difference between patient autonomy and MCA best interests, such as the one I discuss here

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Can-a-verbal-refusal-of-CPR-be-legally-binding/1072/>

my position on ‘patient autonomy’ is that if the person was mentally-capable until the cardiopulmonary arrest happened, then whether or not there is a written ADRT refusing CPR, anyone who is sufficiently certain that the person had made clear he/she would not want CPR to be attempted in the situation of the arrest, should neither attempt CPR nor do anything to promote the attempting of CPR.

On the eve of a naval battle, at a meeting with his Captains to discuss his plans for the battle, Nelson said ‘No captain can do very wrong if he places his ship

alongside that of the enemy'. Providing the situation is one of a capacitous patient suddenly becoming incapacitous, I would support the idea that 'No person will do wrong if he or she is following the expressed wishes of an informed patient'.

APPENDIX 2: CPR and Grievous Bodily Harm

I'm not sure how well this is understood, but the law doesn't say that doctors and other clinicians who perform CPR are 'immune from being charged with Grievous Bodily Harm (GBH)'. What the law provides, is a defence against that [and any lesser 'assault'] charge.

Sometimes clinicians will argue that when a trained clinician attempts CPR, then CPR is a treatment – and when a member of the public attempts CPR, then CPR is first-aid. That completely misses the point: without a legal defence to fall back on, anyone who attempts CPR could be charged with assaulting the patient.

The legal defence, resides in the Mental Capacity Act: usually the defence will be a 'best-interests defence', which rests on section 4(9) of the MCA. In theory anyone who performs CPR – so a doctor, a family-carer, a nurse, a paramedic, a person who shares a home with the person who has arrested, the woman on the street: **anyone** – could be charged with assault. *It is **the same defence** for doctors, 999 paramedics and family-carers and for welfare attorneys.* If we think of the MCA as 'setting out the rules' which a person making a best-interests determination must follow, then the 'rules' are exactly the same for a doctor, a welfare attorney and a family-carer.

What changes if a welfare attorney with authority over CPR says 'attempted CPR would be against his best interests' is that the defence against being charged with assault is removed for everyone else: see sections 6(6) and 6(7) of the MCA.

In reality, I'm not aware of any case when a relative has been prosecuted for attempting CPR when it was legally inappropriate (for example when an ADRT very-clearly forbade CPR in the situation of the arrest, and the relative was

aware of that). And clinicians – but not family-carers and relatives - usually need to also have a legal defence for not attempting CPR.

I have discussed the law, and the way it is different for family-carers and clinicians, in a piece at:

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/DNACPR-at-Home-and-a-Twitter-thread-what-is-the-legal-situation-for-relatives/1110/>

Anyone who finds that piece interesting and/or informative, might also be interested in:

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/The-Policy-in-Wales-now-seems-to-be-to-offer-CPR-to-patients-who-request-it-even-if-the-clinicians-believe-CPR-could-not-work-and-I-approve-of-that./1116/>

<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/>

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/The-thing-is-many-or-most-of-us-DONT-talk-about-CPR./1128/>

APPENDIX 3: a suggestion for a new approach to ‘DNACPR forms’

I have concluded that the best approach to DNACPR documentation, is not to record ‘recommendations’ on a form, but instead to have statements from those deeply-involved and/or who might be present when the person had a cardiopulmonary arrest, to **record what I myself would do if the patient arrested now.**

See:

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

An earlier piece about the interactions between 999 paramedics and family-carers and relatives, can be found at:

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/I-have-a-suggestion-for-how-family-carers-and-999-paramedics-could-be-reconciled-for-CPR-decision-making-feedback-from-family-carers-welcomed./1031/>

I also have an issue with the phrase 'futile CPR' which I think should be banned:

<https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/The-non-offering-of-Futile-CPR-by-doctors-a-concept-past-its-use-by-date/1154/>