The MCA Section 4 – and much more

Forenote: this was piece written as a reply to some of my contacts, and because it still makes sense without rewriting it, I'm going to publish it still in the form that I sent to my contacts.

Hi Everyone,

I'm going to cover two things.

I'm going to start by commenting on John's piece which Lucy pointed me at, which I'm looking at from my idiot-non-lawyer position, and I'll be including my 'verbal refusal of CPR' issue in this, because an e-mail exchange that Alex and I had seems to link to what John is writing about.

Then I'll move on to something else Lucy asked (I think she asked – she might have just said 'have you read?') which was for my comments on the NMCF report.

I'm attaching John's paper, the 2007 Joint CPR Guidance, and also [as usual] this itself as PDF [rather than trying to paste it into an e-mail].

I'm going to start with e-mails between John and me (and John will not get any further e-mails from me unless I'm invited – the rest of you are being given no such promise, as you explicitly write about the MCA and are active in the NMCF) and much as I would like to, an analysis of the benefits of professionals actually engaging with layfolk has no place here [although John does touch on that].

My e-mails with John

Dear Mike,

I've returned to work this morning, and have an enormous number of pressing obligations that I have to attend to and a large pile of e-mail that has amassed.

I've seen your various e-mails. On s.4, I know well what it does and doesn't cover (i.e. specifically that it is simply where such detail as there is is given to the best interests standard), and don't think that that footnote should be taken to mean that it is under section 4 that appointment of whoever "D" might be is authorised. And on the piece that I think you're intending to publish today - I don't have time to work/engage on such short deadlines, I'm afraid.

I hope you understand - I do recognise the salience of your concerns, and the importance of these matters being discussed in public fora.

With best wishes,

John

Hi John,

The e-mails I sent early in the weekend were a bit chaotic (PDFs less so) - but when at some time your workload permits, I would like your answer to the question I sent yesterday. If 'the attitude' was to regard 'those close to the patient as experts', in the same way that clinicians are regarded as experts, would MCA Best Interests be more like 'normal law'?

Best wishes,

Mike

Hi, Mike.

I think probably that question as a comparative one is not well addressed to me - I suspect that there are divergences in fact-finding approaches across different legal domains, including in turn as regards the (relative and direct) treatment of different forms of expert evidence. So I would address that to someone who engages in comparative research on the use of evidence across different courts and tribunals.

What I would say in case it seems I'm just trying to duck the question (!) is that on my readings of CoP cases, I am not sure that expertise is such a significant framing device for judges' reasoning as regards a best interests decision. That is, I don't think it would weaken anything to allow personal proximity to be characterised as endowing someone with something that gets called expertise, but I'm not sure it would strengthen anything either. I see judicial approaches to best interests as involving a survey of different bases of knowledge and understanding, but such resolution and/or synthesis as there may be in an overall judgment on best interests does not seem to me to be obviously determined by reference to expertise.

All the best,

John

When I read John's paper, it seemed to me that it was [mainly] making two points:

that what you see happening when judges are applying MCA law, and in particular the best interests part, doesn't really fit with what happens in much other law,

and

the way the MCA is written seems to be leaving judges a huge amount of discretion – so the judge can arrive at 'almost any decision at all'.

I'm really interested in the first of those – I think they are at the heart of a disagreement I have with Alex. As for the second: I think the problem is the way the MCA is presented. I stress **presented** because I'm going to present things differently, but I will argue without changing 'what the MCA is saying': cf Quantum Mechanics which was originally proposed in two apparently very different versions, Matrix Mechanics and Wave Mechanics, but they both lead to the same results as was proved by Paul Dirac. When I asked Chrome 'Why was Wave Mechanics more popular than Matrix Mechanics' the AI reply was:

Wave mechanics became more popular than matrix mechanics primarily because it was more intuitive, familiar, and computationally accessible to physicists trained in classical field theory. While matrix mechanics (Heisenberg, 1925) used abstract, difficult matrix algebra, Schrödinger's wave mechanics (1926) offered a, for the time, familiar framework of partial differential equations.

E-mails were exchanged between Alex and me, when we were both contributing to a paper back in 2020. I can't find the one I sent to Alex – I only seem to have kept Alex's reply [reproduced in a piece I wrote] – but my point was almost certainly this:

As I said in a voice recording which you might have received alongside this PDF, if you discuss CPR with a patient for 30 minutes, during which you make certain that the patient understands CPR and its clinical outcomes, and during which the patient makes it clear he is refusing CPR, and then before you walk away the patient arrests, you have no doubts that the patient has refused CPR in the situation.

Whereas if an unconscious patient arrives, accompanied by a written ADRT refusing CPR which you have never seen before, and if you have not previously talked to that patient recently, then you are faced with pondering various uncertainties, not least 25(4)(c).

Alex didn't – perhaps still doesn't – like that argument, and Alex sent:

Recognising this is very lawyerly, there really is an important distinction on the head of the pin between acting on contemporaneous, capacitous refusal – which is binding – and the position where the person does not at that point have capacity to consent to or refuse the intervention. Whilst the common law provided for advance decisions (including life-sustaining ones) which could be verbal, the statutory provisions in the MCA make clear that they have to be written and comply with the relevant provisions. What you are arguing for (and I quite understand why you are) is for the survival of a common law refusal post incapacity. My short point is that whatever the common law may have said, Parliament has now spoken, and the courts would not accept that you could simply get around the statutory requirements by saying 'it doesn't matter that the advance decision (because it is an advance decision) isn't in the statutory form because the common law survives.'
This would simply drive a coach and horses through the ADRT regime, so the court would, if it had to, find that whatever common law provision existed has now disappeared.
This is why the doctor/paramedic is in s.5 territory because they need to know whether or not providing CPR is lawful, and that is governed by s.5 MCA 2005 where the person lacks capacity.
But you end up at the same point in the case you described because there would be nothing sensibly to put in the balance against the person's very clearly – and very recently – expressed desire not to have CPR.

I am not arguing that Statute doesn't replace common law – I've forcefully argued that we should all be applying the MCA and not 'legacy beliefs'. But Alex started by missing the blindingly obvious – **you cannot express** a *contemporaneous, capacitous refusal – which is binding* for CPR. **By its very nature you are unconscious at the time you would need to express a contemporaneous refusal of CPR!** The closest you could get, would be to say to a doctor 'I'm forbidding CPR, and I've got a feeling that I'm about to arrest' and to then arrest seconds after having said that.

Doctors seem to have got this right in 2007, when they said in the Main Messages section of the Joint CPR Guidance:

If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision refusing CPR, this should be respected.

To rephrase my '… got it right in 2007': that must be what doctors believed must be the situation, based on their working situation and their thinking about the law.

But when Expected Death Policies were being written ca 2010-2014, they were all saying [based I think on 'copying' the South Central policy – and I can't currently find that policy, so I can't quote the exact wording but my version here is not misleading] 'A verbal refusal of CPR is not legally binding, but must be considered as part of a best-interests decision about CPR'.

As I've pointed out in my recent writing: **you can't in reality perform a section 4 best-interests determination while a person is in arrest, either!**

Alex's '*But you end up at the same point in the case you described because there would be nothing sensibly to put in the balance against the person's very clearly – and very recently – expressed desire not to have CPR.'* is in fact conflating two slightly different situations: it is **not** 'very recently' if the person arrests before the doctor has left the bedside, but it is 'very recently' if the conversation was in the morning and the arrest is in the evening [or, for my at-home situations, if you have daily presence with your loved-one, but not a continuous presence]. It is also not quite ongoing face-to-face if the listening doctor walks to an adjacent ward, and tells another clinician about the conversation: the other clinician wasn't listening to the conversation. That – on my formulation of this – is where the 'boundary issues' reside: when do we start to reasonably question if the person might have had a change of mind since we last talked to the person?

I'm not sure what version 2 of the Joint CPR Guidance said (it isn't easy to find older versions) but the current version seems to be the 1st revision (2024) of the 3rd edition (2016). That sticks with the wording (modified) from the 1st edition:

If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision to refuse treatment (ADRT), specifically refusing CPR, this must be respected.

in its Main Messages section.

It is clear that if the wording used for a patient with capacity refusing CPR and a valid and applicable ADRT refusing CPR is 'must be respected' for both, then as the latter is accepted as being 'legally binding' the former must also be legally binding [in the opinion of this Guidance].

The discussion immediately prior to the arrest is definitely an Informed Consent/Considered Refusal conversation – the doctor's legitimate questions are all of the 'do you understand that if … ?' variety. And it seems deeply perverse, when the patient arrests with the doctor absolutely clear that CPR should not be attempted because of a Considered Refusal conversation, to argue that the doctor then withholds CPR on best interests grounds. Especially as clinicians are familiar with Informed Consent and are on much less-certain territory with Best Interests, and when applying either way-of-thinking [as Alex admits] gets you to ‘you must not attempt CPR’. Furthermore, the possible ‘charge against’ the doctor or other clinician would be ‘you should have attempted CPR’, and ‘I spent 30 minutes talking to the patient, who made it crystal clear that he was refusing CPR’ would be the same, identical, defence whether the doctor was thinking/arguing on either Considered Refusal or Best Interests grounds.

I stress, my objection is to the assertion that without a written ADRT, the decision must be made on best-interests grounds and therefore cannot be ‘legally binding’: I’m not arguing that a verbal refusal can be a valid ADRT (though Hayden’s wording is interesting: ‘He may not have prepared a document that complies with the criteria of section 24, giving advance directions to refuse treatment but he has in so many oblique and tangential ways over so many years communicated his views so uncompromisingly and indeed bluntly that none of his friends are left in any doubt what he would want in his present situation.’).

I’m perfectly happy, to [almost – see below] stick with the Joint Guidance’s ‘*If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision to refuse treatment (ADRT), specifically refusing CPR, this must be respected.*’, so long as we don’t impose on clinicians the equivalent of ‘You must use Matrix Mechanics, which you struggle to understand and apply, and not Wave Mechanics, which you find much easier to understand and apply, to get to the answer – despite the fact that whichever you use, you should get the same answer’.

John’s paper frequently mentions ‘wisdom’ and the need for judges to apply wisdom when making rulings based on the MCA. I will now introduce some ‘wisdom’, and slightly rephrase what I’ve been saying about these verbal refusals of CPR during ongoing contact while the patient is capacitous.

If a doctor has that 30-minute conversation about CPR with a patient in a hospital bed, and the patient makes it clear that he is informed and he is forbidding CPR, and then arrests before the doctor has left the bedside, that is the most legally-compelling of any scenario, in terms of **understanding of** the refusal.

Ditto with a similar conversation at home, between father and son. And as a former family-carer, who had a similar type of conversation while my mother was dying, my position is simply ‘**I know – because I’ve been told’**.

I definitely view this as being in the ‘autonomy’ bucket because it resolves any issues such as 25(4)(c), and those issues remain when we modify the scenario and introduce a written ADRT but remove the face-to-face conversation. But I can see why Alex insists it is a best-interests situation.

The thing is, we often read in ‘guidance’ the phrase ‘is legally binding’. Which is misleading for CPR. Because we are not comparing the making of a best-interests decision in those ongoing-contact situations with a written, valid and applicable ADRT. We are comparing a written valid ADRT, in

an unconscious patient arrives, accompanied by a written ADRT refusing CPR which you have never seen before, and if you have not previously talked to that patient recently, then you are faced with pondering various uncertainties, not least 25(4)(c).

with best-interests decision making in

if you discuss CPR with a patient for 30 minutes, during which you make certain that the patient understands CPR and its clinical outcomes, and during which the patient makes it clear he is refusing CPR, and then before you walk away the patient arrests, you have no doubts that the patient has refused CPR in the situation.

The person considering the written ADRT decides whether to consider it applicable, and only having done that does ‘DNACPR become legally-binding’ – and the person in the situation without the written ADRT considers whether section 4 allows any legitimate justification for the attempting of CPR, should immediately conclude that it doesn’t, and having concluded that then ‘DNACPR becomes legally-binding’.

What we should in fact be writing, is

If a patient with capacity verbally refuses CPR during a situation of ongoing contact, or a patient lacking capacity has a valid and applicable advance decision to refuse treatment (ADRT), specifically refusing CPR, this must be respected.

Let’s think of that conversation between the doctor and the patient. When it ends, the patient says ‘So – now that I’ve told you my decision, you definitely will not be attempting CPR, then?’. The doctor, according to Alex, must reply ‘Well, not exactly – I am required to make a best-interests decision when you arrest’. Clearly then we get ‘But I thought we’d just agreed, that I’ve made the decision!’ from the patient. At least – from any NORMAL patient. **Let’s make our patient an abnormal one – let’s have the patient saying ‘Have you read Wye Valley? Judge Jackson said ‘I am quite sure that it would not be in Mr B's best interests to take away his little remaining independence and dignity in order to replace it with a future for which he**

understandably has no appetite and which could only be achieved after a traumatic and uncertain struggle that he and no one else would have to endure. There is a difference between fighting on someone's behalf and just fighting them. Enforcing treatment in this case would surely be the latter' in a situation when the patient was incapacitous while the treatment was being considered. Are you saying, that after I arrest, and when I've just explained my capacitous decision, that you have got the right to 'fight with me' and to then impose on me an uncertain outcome of CPR which I and no one else will have to live with?'.

Until it is possible to give a sensible answer to that clued-up patient's question, we should stick to, for out-of-court explanations of verbal refusals of CPR, the **wise** version in the Joint Guidance:

If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision to refuse treatment (ADRT), specifically refusing CPR, this must be respected.

and STOP WRITING IN GUIDANCE AND PROTOCOLS the **unwise** 'A verbal refusal of CPR is not legally binding, but must be considered during CPR decision making'.

The reader can legitimately ask 'Why is Mike arguing that one form-of-wording is wise, even though he has argued it needs modification, and that another form of wording is unwise?'. Well, the wording I like is logically correct except it needs a qualification to be inserted, whereas I believe the other form of wording is logically incorrect. Also, the wording that I describe above as 'wise' is the wording the Main Messages section of the BMA/RCN/RC(UK) guidance about CPR decision making actually uses. But I don't really think of those reasons as particularly 'wise'. The wisdom is this: if [misleadingly] you write 'a verbal refusal of CPR during capacity must be respected' then it is almost certain that anyone who reads that, will also have read 'a verbal refusal of CPR is not legally binding'. Which should lead to 'further thinking about what is going on', and should lead to the type of analysis I have presented above. Whereas a person who reads 'A verbal refusal of CPR is not legally binding' is much less likely to then work out why that assertion doesn't stand up to analysis.

In passing, I will add that 'this must be respected' is better wording than 'is legally binding'. And that 'legally binding' does not appear within the Act.

Continuing the discussion of John's paper.

For me, a strong theme amounted to 'the MCA is virtually impossible for a judge to actually apply'. Which I'll express differently, as 'reading sections 3 and 4 they look theoretically correct, but section 4 is formulated rather like a mathematical equation when we are told what the variables are, but not the multipliers'. So, it looks rather like

$BI = a(F1) + b(F2) + c(F3) – d(F4) – e(F5)$ etc

with us being told the what the Fs are, but with no information about the a, b, c etc. Which is right: the a, b, c etc are dependent on the person-as-an-individual.

However: what we are missing, is that only the people who know the person have any idea as to what a, b, c etc will be, **and human experts do not limit themselves to applying that 'equation' when they think.** I'll digress for a minute, to point to something I pointed out in a piece discussing section 2

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/Section-2-of-the-Mental-Capacity-Act-should-be-unnecessary/1165/

I wrote in my piece:

'It makes it clearer, if we re-present section 3(1) as:

3(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—

(a) to understand the options and outcomes of the decision,
(b) to retain the options and outcomes,
(c) to think about the options and outcomes as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means).

Just to be clear, the outcomes of a medical intervention are the functional outcomes - 'what the person will be capable of doing, recovery times, etc'.

Consider the challenge of working out which meal a person would select from a restaurant menu. Not exactly a medical treatment, but …

I never met my friend Rachel, we've only ever exchanged e-mails, texts and talked on the phone. Aside from Rachel, the people who are best placed to opine on what she would select from a menu, are people who regularly ate with Rachel in restaurants. Even her family who lived with her, and doubtless shared meals at home with her, saw a slightly different thing if Rachel was eating at home.

I'm sure Rachel liked lobster – she said to me that if it wasn't so expensive, she would eat lobster 'all the time'. Or perhaps she said 'every meal' – I remember 'meanings' better than wording.

One Christmas, I got Rachel and a couple of friends to answer 'Which foods have we eaten during the fortnight around Christmas?' (having heard a suggestion on Radio 4 that we should be eating 40 different types of food each day, or perhaps each week). My e-mails included a list of foods eaten by [although I suspect Rachel might have included 'prepared and available in her home', not necessarily eaten by her] Rachel. Of course, the question was 'select from a restaurant menu'. We might be faced with 'I know Rachel likes three things on that plate a lot, but she has never told me she has eaten the fourth item: does she hate it?' compared with 'Rachel eats the things in this meal, but I didn't get the impression that they are 'favourite foods''.

Best Interests determinations, are like that: complex.

It is now immediately clear, that a judge alone couldn't make any best-interests decision, because without the **expert clinical input** the judge wouldn't know what the options and outcomes were. A doctor could make a best-interests determination, without any understanding of the patient as an individual, but not an individualised determination: it would have to be based on the concept of 'the average patient'.

I don't think I agree with John's '*I don't think it would weaken anything to allow personal proximity to be characterised as endowing someone with something that gets called expertise, but I'm not sure it would strengthen anything either.'.* It seems difficult to deny that Hayden is regarding the family and friends as providing expert opinion when he writes

He may not have prepared a document that complies with the criteria of section 24, giving advance directions to refuse treatment but he has in so many oblique and tangential ways over so many years communicated his views so uncompromisingly and indeed bluntly that none of his friends are left in any doubt what he would want in his present situation.

But I need a judge to describe ‘those close to the patient’ as experts.

I once exchanged e-mails with a doctor, who on Radio 4 had said ‘I think the expert hunch is very scientific’. She admitted she had been wrong by return e-mail. What she meant was that experts have ‘hunches’ which are often well-founded and right, and stem from expertise – but the reason it is ‘a hunch’ or ‘intuition’ is, to put it simply, ‘you know it but you can’t explain why you know it’. So it isn’t scientific. I believe, it is subconscious pattern recognition. I think our minds evolved to process things in terms of pattern recognition. Look around you, and you seem to be seeing a huge amount of visual information: give most people even a fairly simple bit of maths to do under time pressure, and most people struggle, even though there isn’t much reasoning and information processing involved in the maths. We didn’t use maths, or even language, to decide which was the path to take to make it more likely that we wouldn’t encounter a tiger.

I used to use an analogy about stroking a dog. If you see a strange dog and its owner, and you want to stroke it, you don’t ask its owner to explain how the dogs thinks. You ask ‘Can I stroke your dog, or will he bite me?’. You might get ‘He’s friendly – he won’t bite you’. You could get ‘He’s okay with everyone, except he tries to bite anyone wearing a red hat’ or ‘… bite left-handed people – baffles me as well!’.

What I’m getting at, is ‘experts in the individual’ - close family and close friends – do not in reality use that equation with all of those a(F1), b(F2), etc, terms. Many of the Fs are in the outcomes as described by the clinical experts: the experts in the individual will also be considering ‘wider-life Fs which will arise as the person lives out his different future outcomes’; and these experts will not be explicitly thinking ‘a = 3, d = -6, etc’. **The experts will be using ‘expert intuition’ to compare how the person would be/feel inside the various possible futures**.

So, with the ‘clinical experts describe the options and outcomes’ then ‘experts in the patient as an individual’ tell us ‘what the patient would have chosen’ approach/mindset, the judge doesn’t need to try and perform that ‘balance-sheet exercise’ which even some judges have said isn’t helpful as an approach.

It really shouldn’t come as a surprise, that for a concept which stresses the person as an individual, an understanding of the person as an individual best-equips a person to apply the concept.

So, I think it does make a difference, if we are explicit: the clinicians describe the clinical things which they understand, then [if they are available to do so, and feel able to do it] close family and close friends* do the section 4 bit, so the judge [or anyone else making a determination] isn't being required to 'do the impossible'.

* In some situations, you only need the 'close' bit, less so the family or friends. Suppose someone is badly smashed-up in a car crash, unconscious, and all of the options would lead to life-limiting consequences. And perhaps the 'minimal intervention' option would lead to death. Think about WW2, and how lots of people came back from the war and never talked about it to their families. Move this to now, and make the patient a combat soldier who has been involved in brutal fighting and many comrades have been badly injured. He might have expressed relevant views to his fellow soldiers, even to people he is serving with who are not his 'best friends'. Who is most likely to understand section 4 – the wife who he has been shielding from the horrors of war, or the comrades he served alongside?

See also:

https://blogs.bmj.com/spcare/2024/02/01/best-interests-a-term-that-covers-many-concepts/

My Answer to Lucy's Question about the NMCF report

Overall, there is still a lot of work to be done. Much of that seems to concern the 'deprivation of liberty' aspect, which is not 'my thing'. Lucy's section on DLS definitely gives me a suspicion, that changes to the MHA could well make things worse at the patient end of things. I didn't really look at the case studies, because most seem to be more 'social' than 'medical intervention'.

The Coroners section I didn't read, although as it happens my first issue back in 2008 was 'what does sudden death mean?' and that impinges on both family-carers and 'coroners', and that I have written about:

https://www.dignityincare.org.uk/Discuss-and-debate/download/275/

I only glanced at Alex's bit about cases: the first case I'd discussed with Lucy and others, and I've got on my 'to do list' to look at the Hayden case

https://www.bailii.org/ew/cases/EWCOP/2024/17.html

I'll definitely comment on the DNACPR section – my thing!!! – but first I'll comment that I also haven't read in any detail the sections after the DNACPR bit, however from scanning them I suspect they are 'good resources'.

So, to

Developing a Consensus Statement about "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) – A Consolidated Draft

I'll start with something I've recently asked BMA Ethics about.

On page 40, Ben Troke acknowledges the contributions of several Forum members. Just three of his memorable proposals merit consideration: rename the MCA: "Making *This* Decision Act;" …

I've asked the BMA, why we aren't reading about, and being told about, CNACPR forms. While most people have twigged that DNACPR forms cannot be 'Orders', and these days they tell readers that they are 'recommendations', nobody seems to have noticed that DNACPR means Do Not Attempt CPR. And if the forms are recommendations, they are CNACPR forms – 'Consider Not Attempting CPR forms'. If we want informed patients and relatives, then clinicians shouldn't be saying 'I'll go away and complete a DNACPR form for you' to patients on hospital wards when the reality is they are going to return with a completed CNACPR form.

If the patient notices that, and asks the doctor 'Hang on – I told you I definitely don't want CPR and I'm refusing CPR – but this form is only a recommendation' then presumably the doctor will say 'then you need an Advance Decision refusing CPR'. So, they complete an ADRT. The patient then says 'This looks better – it says it is my decision to forbid CPR – so will this definitely stop anyone from attempting CPR?'. Let's suppose the doctor says 'Yes – it should'. Then the obvious comment from the patient, is 'So we don't need a DNACPR form, which is only a recommendation, when we've got my ADRT refusing CPR, do we?'.

We should also change CPR documents, in the way I've argued for 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/

See a BMJ rapid response Mark and I jointly submitted:

https://www.bmj.com/content/386/bmj-2022-071661/rr

So – the start of the DNACPR section:

The Context

A decision about accepting or refusing to have CPR may be made at any time by a person with the capacity to do so. This information should be documented and known to GPs or medical teams. It should result in a GP or medical team recording a DNACPR recommendation and completing a DNACPR form. The latter should be clearly visible in a person's records and shared with all teams that are likely to be involved in a person's care.

I've already discussed the issue of accepting or refusing CPR at any time if you are capacitous, with my analysis about verbal refusals of CPR. The word 'refusing' doesn't fit with 'DNACPR recommendation' and we should replace DNACPR form with CNACPR form. We should also, as it does fit with 'refusing', insert into **this** paragraph '*It should result in a GP or medical team helping the patient to create a written ADRT refusing CPR'* and, <u>if we stick with the logic</u> I've just outlined above, **dump** this 'recording of a recommendation in the patient's records' because we've just created a decision.

We should also, replace

The existence of a documented, Advance Decision to Refuse Treatment lets a GP or medical team know that a person wishes to refuse a clearly specified treatment in the future. This legally binding instruction may cite CPR, for example. It should be readily accessible in the documentation concerning DNACPR.

with

The existence of a documented, Advance Decision to Refuse Treatment lets a GP or medical team know that a person is refusing a clearly specified treatment, should the treatment be considered during future incapacity. This legally binding instruction *may cite CPR, for example. It should be readily accessible in the documentation concerning DNACPR.*

ADRTS are NOT an expression of wishes!

This

7. Decisions about (i) Cardiopulmonary Resuscitation (CPR) and (ii) Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) recommendations are not trumped by organisations' policies stating, for example, that CPR should ***always*** *be applied.*

is true, and I think Mark and I both independently complained to one of the Welsh regions about such a policy a few years ago. But I'm not convinced that all nurses, if alone with a patient at 10pm on a Sunday evening, would follow a patient's verbal refusal of CPR.

11. The consent of a patient or another person with legal authority is not required for a DNACPR recommendation – but the need for consultation and openness is paramount. There is a duty to consult.

I don't like this. I think that we should remove the 'CPR couldn't work' justification from almost all situations, as I've argued:

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/

There is a link in that piece, which goes to my earlier piece which argued that we should attempt CPR if a capacitous patient, having been informed of the risks, had said 'I want you to attempt CPR anyway'. And my main motivation is the hope that would result in **fewer** people wanting CPR, and more people refusing CPR: because more relatives would then [temporarily I hope! - if more relatives witnessed the reality of CPR being performed, then I would expect fewer people would want CPR in the future] see what Mark and Adam Kay have explained – and seeing it happen to your dad, would I'd assume prompt 'I don't want that for myself!!!'. I also have an argument around certainty: for other treatments it is the capacitous patient who decides whether to accept the risks of the treatment, and that doesn't seem to be happening with CPR.

It is possible that the real legacy will be the persistence of sustained and thoughtful debate which bring to the fore examples of reflective practice. For example, the Resuscitation Council UK promotes ReSPECT – a Recommended Summary Plan for Emergency Care and Treatment.52 The ReSPECT process creates recommendations for a person's care and treatment in the event of a future emergency in which they may be unable to make or express their wishes.

It takes too long, and raises my blood pressure too much, for me to regularly elaborate on my dislike of the ReSPECT form: why no signatures of welfare attorneys on it; why when the Act says *'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),'* and when confirmation that I wrote something is normally my signature, isn't the patient allowed **to complete and sign** the section of the ReSPECT form covering a patient's 'wishes'; etc.

How do we change things?

I wrote a short JME blog piece

https://blogs.bmj.com/medical-ethics/2021/02/21/is-there-only-one-mental-capacity-act-or-are-there-two/

in 2021, and I ended it with this:

Clinicians are very influenced by 'advance care planning' – which is in essence not legally-binding, and does not appear to me to sufficiently-involve family-carers. The NHS 'seems to prefer' DNACPR forms (signed by doctors and not 'legally binding') as compared to written ADRTs (signed by the patient and 'legally binding'). As a former EoL family-carer, I was informed by conversations: whereas 999 paramedics seem to be overly-influenced by what has been written down.

After a decade of involvement in EoL/MCA/CPR debate, I still find that when I read the Mental Capacity Act as a former family-carer, I seem to be seeing something very different from what clinicians see when they read the Act.

How can we achieve good and joined-up care for people who are dying at home, with relatives and clinicians working together to support patients, if relatives and the 999 Services cannot even agree on the law which should be guiding everyone's behaviour?

I think we need ‘challenge from patients’.

Patients should demand to complete and sign the ‘my wishes’ sections on forms;

Patients should ask ‘If I’ve got an ADRT refusing CPR, why do we need one of your ‘advisory’ DNACPR forms – and why aren’t those things called CNACPR forms for clarity?’;

If a doctor says ‘We are having a meeting so that I can decide what is in your dad’s best interests’ then we should forcefully assert ‘No! We are all having a meeting to see if we all agree about what is in dad’s best interests’.

Etc.

Written by Mike Stone, February 2026

The MCA world and the world of Mobile Phones

The MCA world, has swept away some earlier legal concepts. For example, although Twitter seemed to have revealed that some doctors hadn’t realised it, the MCA swept away the defence of ‘Necessity’: now, the defence is that the doctor didn’t have the opportunity to ‘harvest’ and then apply the information within section 4(6).

We also increasingly live in a world, where it seems ‘everything has been recorded on video’. Suppose the discussion between the doctor and patient in a hospital bed (page 6) is fully-recorded on video, and includes the doctor’s actions when the patient has the cardiopulmonary arrest. You might be thinking that I’m about to argue that the video somehow stands-in-lieu-of a written Advance Decision: I’m not, and I do know what ‘in writing’ means.

I’m going to consider the situation of the doctor attempting CPR, with everything recorded on video. It seems to me that the doctor would be charged with assault. And what I am going to argue, is that the assault case would be tried in our criminal courts, and that it is very difficult to see how the doctor could avoid being found guilty. Furthermore, I’m not at all certain that the MCA and its best-interests framework would even be mentioned, during an assault case in a criminal court.

Of course, if attempting CPR would leave the doctor open to being charged with assault, and if it seem ‘impossible’ to defend yourself against that charge, then the doctor’s only sensible option is to withhold CPR.

When the Supreme Court withdrew PD9E the court didn’t say that applications for best-interests rulings about the withdrawal of CANH could no longer be made to the court – it said that if the clinicians and the ‘family’ were **all in agreement** that withdrawal of CANH would be in the patient/loved-one’s MCA Best Interests then there did not need to be an application to the court. It is obvious that the agreement has to be about best interests – not about the patient/loved-one’s favourite food, or dress sense, or whatever. When the medics (from vague memory, it was BMA/RCP guidance) wrote up their CANH guidance following the ruling, they did state that the MCA does **not specify** who can make a best-interests determination. Then they produced various arguments, to try and effectively arrive at ‘although the Act doesn’t say it is the doctor who makes the best-interests decision, it is the doctor because [various reasons]’. One of the arguments given was ‘making the best-interests decision is part of the doctor’s Duty of Care’. Now: so far as I can see, ‘Duty of Care’ was swept away by the MCA, in the same way that the defence of ‘Necessity’ was swept away. **It seems to me, that in the MCA world, the doctor is required to be clinically-competent, and is also required to correctly-apply the MCA**. That being the case, ‘where does duty-of-care’ fit in?