

Do not attempt cardiopulmonary resuscitation decisions: joint guidance

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Abstract

Since its introduction in the 1960s as a treatment to restart the heart after sudden cardiac arrest from a heart attack, attempts at cardiopulmonary resuscitation have become more common in other clinical situations. Cardiopulmonary resuscitation can be a lifesaving treatment, with the likelihood of recovery varying greatly depending on individual circumstances; however, overall, the proportion of people who survive following cardiopulmonary resuscitation is relatively low. Anticipatory decisions were recognised as being the best way of ensuring that cardiopulmonary resuscitation was not attempted against individuals' wishes.

Since 2001, the British Medical Association, Resuscitation Council (UK) and Royal College of Nursing have published professional guidance on decisions relating to cardiopulmonary resuscitation. The latest version of this guidance was published in June 2016. This paper summarises the key legal and ethical principles that should inform all cardiopulmonary resuscitation decisions, with particular emphasis on the recent changes in law and policy.

Keywords cardiopulmonary resuscitation, decision making, do not attempt cardiopulmonary resuscitation, professional guidelines

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Background

Cardiopulmonary resuscitation (CPR) was developed in the 1960s as a treatment to try and restart the heart after a sudden cardiac arrest from a heart attack from which someone would otherwise make a good recovery. The success of CPR in these circumstances, along with greater awareness of the procedure and access to resuscitation equipment, means that its use has broadened considerably, and CPR is now attempted by UK hospital resuscitation teams in around 20,000 patients each year.¹

CPR has saved many lives since it was first introduced, but it can also cause harm to some patients. Cessation of heartbeat and breathing are an inevitable part of the natural dying process. In many cases CPR might not work, or might restore heart function for only a brief period, potentially prolonging suffering caused either by their underlying condition, or as a direct result of the CPR attempt. CPR can be an invasive and traumatic treatment; one which can be distressing for those close to the patient and ultimately deprive patients of the type of death they would have wanted for themselves. For this reason, careful consideration is needed in each individual case to decide whether it is appropriate to attempt CPR.

The circumstances in which a decision not to attempt CPR (DNACPR) can be made pose a number of clinical and ethical dilemmas for doctors. Since 2001, the British Medical Association (BMA) has produced UK-wide guidance with the Resuscitation Council UK and Royal College of Nursing that outlines the key ethical and legal principles that should inform all CPR decisions.² The guidance also outlines where capacity legislation differs between the four nations. The latest update of this guidance was published in mid-2016 in response to key legal cases heard in England. These cases engaged both English law and UK-wide human rights legislation, and so developed national policy around how DNACPR decisions should be discussed with patients.

Although the key principles remain the same, there is now greater emphasis on high-quality communication, decision-making, and record-keeping.

When should a DNACPR decision be considered?

For many people receiving medical care, the likelihood of cardiorespiratory arrest is low. Where this is the case, there is no ethical or legal requirement to initiate discussion about a patient's wishes in the event of a cardiorespiratory arrest. For patients where there is an identifiable risk of

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cardiorespiratory arrest, it is important to make decisions about CPR in advance so that a decision is not needed at a point of crisis.

Although the ethical principles underpinning decisions around CPR apply to all patients, in all settings, CPR decisions must be made on an individual basis. It must not be assumed that the same decision will be applicable to all people with a particular condition; nor is it appropriate to make a decision on the basis of a person's age, disability or a subjective view of the patient's quality of life.

Each decision about CPR should be reviewed if and when appropriate, and when circumstances change; for example, during an unplanned or acute admission to hospital; where there is an improvement or deterioration in a person's condition; or where there is a transfer between care settings.

If a patient suffers a cardiac arrest and no advance decision about CPR has been made, there is an initial presumption in favour of attempting CPR, unless it is deemed to be clinically inappropriate by the attending doctor.

Decisions about CPR where it may be successful

All patients with capacity have the right to refuse treatment, including CPR. Therefore, when a patient with capacity refuses CPR, or when a patient lacking capacity has a valid and applicable advance decision specifically refusing CPR, those decisions must be respected - even if the doctor disagrees with that choice. Advance decisions refusing treatment are not covered by statute in Scotland and Northern Ireland, but would most likely be considered binding under common law.

In many cases, decisions about CPR will be based on a balance of benefits and burden: if CPR may be successful in restarting a person's heart and/or breathing for a period of time, the potential benefits of prolonging life must be balanced against the potential harms and burdens of CPR. This is not solely a clinical decision to be made on the basis of the likelihood of resuscitating someone successfully, and the level of recovery that can be expected post-resuscitation. A decision that CPR will not be attempted, because the risks outweigh the benefits, should only be made following careful consideration of all factors relevant to the patient's current situation, and after discussion with the patient, or where the patient lacks capacity, those close to them. Various other factors relevant to the patient's situation must be taken into account, including:

- the patient's known or ascertainable wishes, including previously expressed views
- the balance of the person's rights under the Human Rights Act 1998, including the right to life against the right to be free from degrading treatment
- the likelihood of the patient experiencing continuing pain or suffering that they would find intolerable or unacceptable
- the level of awareness the person has of their existence and surroundings

People have ethical and legal rights to be involved in decisions that relate to them, and so there is a presumption in favour of involving the patient himself in the decision-making process, or, when the patient lacks capacity, those close to the patient, who can help explore the patient's feelings, beliefs and values in order to reach a decision that is in the best interests of the patient (under the Mental Capacity Act 2005 in England and Wales) or which will benefit the patient (under the Adults with Incapacity (Scotland) Act 2000). In Northern Ireland, where there is currently no specific legislation, mental capacity and treatment decisions for those who lack capacity are governed by the common law.

If, in spite of clinical evidence that CPR is more likely to cause harm than provide benefit, the patient still requests that CPR be attempted, that wish should normally be respected. Although the healthcare team may disagree that the risks posed by CPR are justified by a slim margin of success, it is for the individual himself to accept that chance.

Decisions about CPR when it will not be successful

Where doctors believe there is no realistic prospect of a successful outcome, CPR should not be offered or attempted. It is a well-established principle that treatment that is not in the patient's best interests (in Scotland, of overall benefit to the patient) is clinically inappropriate. Patients or those close to them have no legal right to demand clinically inappropriate treatment and so cannot request or demand that it be carried out.

In circumstances in which CPR will not be successful, there is still a presumption in favour of explaining the need and basis for the DNACPR decision to the patient or, where the patient lacks capacity, those close to them. This was made clear in the recent case of *Tracey* (see Box 1), where the Court of Appeal held that there must be 'particularly convincing justification' not to involve a patient in a discussion about the decision.³ The fact that they might find the conversation distressing is not sufficient reason not to involve them. Doctors must discuss DNACPR decisions with patients unless there is a compelling reason not to, for example if doing so would cause the patient 'physical or psychological harm'.⁴

The subsequent case of *Winspear* (see Box 2) confirmed that these principles applied equally to patients who lack capacity. A decision not to attempt CPR on a patient who lacks capacity must be discussed with any legal proxy, for example, in England and Wales, someone with lasting power of attorney for health and welfare or, in Scotland, a Welfare Attorney or Court appointed Welfare Guardian. If there is no one with legal authority to make decisions on behalf of the patient, the decision should be discussed with the patient's family, friends, or others close to the patient with an interest in their welfare. The updated guidance details the different forms of legal representatives across the four nations in full.

The judgement in *Winspear* made clear that the fact that it might be inconvenient or impractical to inform those close

Box 1. R (Tracey) v Cambridge University Hospital NHS Foundation Trust

Janet Tracey was a 63-year-old woman admitted to hospital following a road traffic accident. Two weeks prior to the accident, she had received a terminal diagnosis of lung cancer. While in hospital she developed pneumonia that, alongside her lung cancer, meant that she required ventilation in the ICU. Her doctors came to the decision that CPR would not be successful and placed a DNACPR notice in her notes. When this was spotted by her family members, they registered their objections and the notice was cancelled. Following subsequent deterioration, a second DNACPR notice was completed and placed on her notes with the agreement of her family. Mrs Tracey died later that same day.

The clinical decision of the medical team was never disputed, but Mrs Tracey's family argued that she should have been consulted on the initial decision to place a DNACPR notice on her records and that a failure to do so amounted to a breach of her Article 8 right to private and family life under the European Convention on Human Rights.

The Court of Appeal held that because the decision whether or not to attempt CPR is fundamentally one about how someone will end their life, it engages Article 8. It found that by not involving her in the initial decision about whether to attempt CPR, her right to respect for her private life had been breached.

to the patient of a decision at a particular time does not necessarily amount to a 'particularly convincing justification', as set out by the court in *Tracey*. In the immediate case, the court held that a telephone call to the patient's mother (his lifelong carer) at 3am to inform her of the decision, although perhaps not as desirable as a face to face discussion in the hospital, would have been 'practical and appropriate' (under paragraph 5.51 of the Mental Capacity Act 2005 Code of Practice).

Communicating decisions about CPR

Decisions around whether or not to attempt CPR raise sensitive and distressing issues for patients and those close to them, and can be extremely difficult. These difficulties are compounded by widely held public misconceptions and misunderstandings about CPR and what it involves. Sanitised depictions of CPR on television medical dramas (which lead to a public perception that the success rate of CPR is around 50%,⁵ compared to the reality of 15–20%⁴); negative media coverage of the way in which DNACPR decisions are made;^{6,7} and a widely held, but incorrect, belief that a decision not to attempt CPR means that all other care and treatment should also be withheld,⁸ all contribute to the difficulties around communicating with patients and those close to them.

Box 2. Winspear¹²

Carl Winspear was a 28-year-old man with cerebral palsy, epilepsy, spinal deformities and various other comorbidities. He lacked the capacity to make decisions about his medical treatment. He was admitted to hospital with a chest infection, where, at 3am, a specialist registrar in cardiology recorded a DNACPR decision on Carl's notes on the basis of his opinion that CPR would be clinically inappropriate. Following a discussion with Carl's mother later that day, the DNACPR notice was cancelled. Carl died later that evening.

As in *Tracey*, the clinical decision of the doctor was not disputed. Carl's mother, however, contended that the failure of the doctor to consult with her (as Carl's main carer) before making the decision contravened Carl's right to private and family life under Article 8 of the European Convention on Human Rights.

The Court held that, it being practical and appropriate to do so, the failure to consult with Carl's mother before placing a DNACPR notice on his medical records amounted to an interference with his Article 8 right to a private and family life.

The recent decisions of the courts in *Tracey* and *Winspear* illustrate the difficulties about when and how to communicate DNACPR decisions with patients and those close to them. Many questions still remain. The court in *Tracey* did not provide any clear guidance on what level of distress would meet the threshold of 'physical or psychological harm' so as to justify not involving a patient in the DNACPR decision. The judges acknowledged, however, that clinicians would often be required to make these difficult decisions in stressful circumstances, and that the court should 'be very slow to find that such decisions, if conscientiously taken, violate a patient's rights.'⁴

Winspear sets a high standard for the circumstances where it will not be 'practical and appropriate' to contact those close to a patient who lacks capacity. In the immediate case, Carl Winspear's mother had been his carer since birth, and was heavily involved in all decisions about his medical care and treatment. The judge noted that: 'Although her willingness to be woken in the small hours was not known to the clinicians at the time, the fact that she had a telephone, had been Carl's carer since birth, had been in the hospital the previous day and had kept in touch with nursing staff would or should have been known.'⁹

As a result of these cases, the joint guidance from the BMA, Resuscitation Council and Royal College of Nursing re-emphasises the importance of high-quality communication. Effective communication is essential in ensuring decisions about CPR are made well and clearly understood by all those involved. There should be clear, accurate, honest and timely communication with the patient and (unless the patient has requested confidentiality) those close to them.

This should include:

- the provision of clear and accurate information about CPR and what it involves
- checking the understanding of what has been explained to the patient and those close to them
- making clear that a DNACPR decision will not compromise the delivery of other care and treatment

Any decisions about whether or not to attempt CPR should be clearly recorded in the patient's health record, and be accessible immediately and easily to all healthcare professionals who may need to be aware of it, including GPs, hospice or care home staff and ambulance clinicians. The guidance underscores the importance of ensuring CPR is not viewed in complete isolation, but explored through discussions as part of advance care planning and overall goals of care. This can go some way to overcoming many anxieties and misunderstandings.

Avoiding or delaying discussions about whether to attempt CPR can lead to misunderstanding, mistrust and damage to the doctor-patient relationship. In line with the judgements from *Tracey* and *Winspear*, the guidance states that delaying or avoiding communicating a decision to a patient must be because that discussion would be likely to cause them physical or psychological harm; where a patient lacks capacity, delaying or avoiding communicating a decision to those close to them must be because communication in those circumstances would not be practicable or appropriate. In both cases, the reasons for reaching such decisions must be carefully recorded.

The court in *Tracey* considered whether there was a legal obligation on doctors to offer a second opinion if a patient disagrees with their treatment options, and concluded that there was not. The joint guidance, however, states that it is good practice to offer a second opinion in the event of a disagreement between the doctor and the patient or those close to them.

Where next?

The full impact of the judgements from *Tracey* and *Winspear* on medical practice remains to be seen. Concerns have been raised about the practical implications of this judgment for doctors' time and workload, if all CPR decisions must be discussed in detail with patients or those close to them. It has also been suggested that out of fear of criticism or litigation, doctors might purposefully avoid considering CPR decisions – leading to an increase in the number of futile (and undignified) resuscitation attempts.¹⁰ Nevertheless, making these decisions is part of good clinical care and doctors should not avoid making them because of fear of being challenged. They should ensure they are familiar with the guidance, follow good practice and make a careful record of discussions that take place and how decisions are reached.

Many difficulties around recording and communicating decisions remain, and work is ongoing in England and Wales on a standardised form on which to record these decisions; a similar initiative has been in place in Scotland since 2010.¹¹ The Working Group for the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), which included representatives from all four nations, has developed a national form to record anticipatory decisions about CPR and other life-sustaining treatment, and to help guide decision-making in an emergency situation where a person lacks capacity. ReSPECT has now been made available for adoption by health and social care communities in the UK. The ethical and legal principles that underpin the guidance on decisions relating to cardiopulmonary resuscitation remain the same and are valid also for the ReSPECT process. Further information about ReSPECT is available at <http://www.respectprocess.org.uk>

The BMA, Resuscitation Council and Royal College of Nursing will continue to support doctors in making these decisions.

Key points

- Decisions about CPR should always be made on the basis of individual assessment of each person's circumstances
- If CPR may be successful, there is a presumption in favour of involving a patient, or for patients who lack capacity, those close to them in the decision-making process
- If a doctor believes that CPR will not be successful, there is still a presumption in favour of explaining the need and basis for the DNACPR decision to the patient, or for patients who lack capacity, those close to them
- Conversations about CPR decisions can be difficult and sometimes distressing for patients. Effective communication is essential in ensuring decisions about CPR are made well and understood by all those involved
- Detailed discussion on the legal and ethical principles to be taken into account in making decisions about CPR can be found in guidance published by the BMA, Resuscitation Council (UK), and Royal College of Nursing²

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