Out of Hours

Law note:

if CPR is futile, do I have to tell my patient about a decision not to attempt it?

TELLING A PATIENT ABOUT A DECISION NOT TO ATTEMPT FUTILE CPR — IS IT NECESSARY?

The busy-doctor answer:

Normally, yes.

In more detail:

Mr Bloggs has end-stage COPD. He knows he's unwell. But he's an anxious man with an anxious family. He hasn't asked you about prognosis. And he's deteriorating. Forward planning seems wise: indeed, the General Medical Council says that, when patients become clinically unstable and there's a foreseeable risk of arrest, a judgement about the likely benefits, burdens, and risks of CPR should be made as early as possible.¹

You reckon CPR would be futile, so a decision not to attempt cardiopulmonary resuscitation ('DNACPR') looks right. Were Mr Bloggs to arrest, pummelling his chest in the back of an ambulance to nowhere will do no-one any good.

So surely there's no need to cause him further distress by discussing this with him? It's futile, so isn't it as relevant as discussing whether you're going to certify him fit to climb Kilimanjaro?

Not so, said the Court of Appeal last year in a case called *Tracey*.² Mrs Tracey had lung cancer and was on a ventilator following a road accident. An intensivist completed a DNACPR form without discussing it with Mrs Tracey (who was apparently conscious and communicating at the time) or her family.

A horrified daughter found out about the DNACPR decision. Mrs Tracey asked that it be withdrawn, and it was. Then she deteriorated. At that point she said she didn't want to discuss resuscitation. In conjunction with her family, a second DNACPR decision was made. Mrs Tracey died 2 days later.

The case was about the first DNACPR decision. Mrs Tracey's husband said that his wife should have been consulted and told about it. And, if she wasn't willing or able to be involved, members of her family should have been consulted.

The Court of Appeal agreed with Mr Tracey: DNACPR decisions are just too important, said Lord Dyson:

'There should be a presumption in favour of patient involvement. There need to be convincing reasons not to involve the patient.'

SECOND OPINIONS

One persuasive justification for expecting us normally to involve patients, even if CPR would be futile, was this: if you don't tell your patient that you've made a DNACPR decision on the basis that CPR would be futile, you deny her the opportunity to seek a second opinion about whether it *would* be futile. I'd venture that most of us have, at some point, been wrong about things like the prospects of successful resuscitation.

A presumption in favour of patient involvement: that means you have to have good reasons not to discuss it. (And you'd be wise to document those reasons.)

One good reason not to discuss it would be if doing so would cause the patient physical or psychological harm. But *harm* is more than *distress*. Many patients may find involvement in this decision distressing, said the Court of Appeal, but that's not enough of a reason to deny them the opportunity. (Perhaps ask yourself: is it my own discomfort that's making me reluctant to raise this?) However, if you conscientiously consider whether to discuss CPR with your patient, the courts will be slow to second-guess you.

When CPR won't work, patients can't require you to provide it.^{1,2} But they are normally entitled to know that you've decided not to. And, if your patient disagrees, the General Medical Council (GMC) would have you explain the options of seeking a second opinion and of getting legal representation.¹

GMC GUIDANCE

The GMC's current end-of-life guidance says this about DNACPR decisions when CPR would be futile:

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*'You should not make assumptions about a patient's wishes, but should explore in a sensitive way how willing they might be to know about a DNACPR decision. While some patients may want to be told, others may find discussion about interventions that would not be clinically appropriate burdensome and of little or no value. You should not withhold information simply because conveying it is difficult or uncomfortable for you or the healthcare team.'*¹

Following *Tracey*, that's a little misleading: your suspicion that Mr Bloggs may find involvement in this decision 'burdensome' probably doesn't justify keeping him in the dark about it. But you'll approach this sensitively. And if Mr Bloggs makes it clear that this isn't a conversation he wants to have, get his permission to discuss it with those close to him.

This is one of several recent cases on patient autonomy in which the normally conservative higher courts are a little ahead of some corners of the medical profession.³

Those in fellowship with tabloid rants about human rights 'gone mad' will take succour from the knowledge that this case was brought under the Human Rights Act.

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You can read more by Adam Sandell at the BJGP blog: <http://bjgpblog.com>

REFERENCES

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2. R (Tracey) v Cambridge University Hospitals NHS Trust [2014] EWCA Civ 822, [2014] 3 WLR 1054.
3. Sandell A. Law note: what treatment risks do I have to discuss with my patients? *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X685801.

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