DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION POLICY

Consultation by NHS Wales

Response from BMA Cymru Wales

INTRODUCTION

BMA Cymru Wales is pleased to respond to the NHS Wales consultation on a proposed all-Wales Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

General comments:

BMA Cymru Wales broadly welcomes the concept of a revised policy to apply across Wales and supports the work led by Dr Paul Buss that has been undertaken towards this aim during the past year. We appreciate having been provided the opportunity to input into the policy’s development at various stages prior to this formal consultation being undertaken.

This response to the proposed policy, which we now submit, is based on observations from doctors working across different branches of practice – including from both primary care and secondary care.

A number of doctors observe that what has been suggested, including specifically the proposed all-Wales DNACPR form, constitutes an improvement in relation to what is currently in place. We consider that the proposed revised approach should help shift the balance towards achieving greater dignity and respect for patients rather than promoting a more risk-averse approach by individuals or organisations fearful of criticism or sanction. The new form is also to be welcomed as being shorter and more straightforward than previous forms.

Moving towards a consistent all-Wales policy is strongly supported by BMA Cymru Wales. We view it as a welcome opportunity to improve on the current situation in which there are different and disparate policies in place in different parts of Wales.

Forms

BMA Cymru Wales strongly supports consistency in moving towards having the same form used in both hospital and community settings.
With regard to the forms currently in use, GPs in particular have raised concerns that they need to be printed on a colour printer and have questioned if this will be the case with the new form.

Whilst, we understand that the use of orange in the current forms may enable them to be more readily identified amongst other paper work by healthcare staff, the need to provide them in colour nonetheless can often present practical difficulties in ‘real world’ usage. Many doctors, for instance, don’t have direct access to a printer that can print in colour, and would therefore much prefer a form they could simply either download and print off, or photocopy. They have described instances where forms have been rejected because they were not in colour and this had led both to delays and increased bureaucracy as forms have then had to be completed a second time.

Given the heavy workload that doctors face, we would therefore ask that consideration be given to the current requirement for the forms to be in colour to be removed.

**Dealing with grey areas**

BMA Cymru Wales has some concerns that the policy, as it stands, may still not adequately address a key issue which exists in previous DNACPR guidelines regarding patients with end-stage diseases. We are therefore concerned that unless this is addressed, the proposed policy could represent a missed opportunity to prevent further cases along the lines of the recent legal challenge against Addenbrooke’s Hospital in Cambridge.¹

Our concern is based on the fact that, as with previous policies, this proposed policy would appear to be based on an assumption that cases can be neatly divided into:

- situations where CPR is futile, and those where CPR is a realistic option about which to make a choice;
- situations where a patient has mental capacity (and can therefore discuss CPR rationally), and those where the patient lacks mental capacity.

We see these two decision points as key, and note that they form the core of the decision algorithm on page 10 of the policy. As such, the proposed policy deals very appropriately with situations where these two issues are clear cut. However, the experience of our members is that in real-life settings these scenarios are very often not so able to be neatly divided and it is in such grey areas that problems lie. Our concern is that a significant number of situations do fall into such grey areas.

With regards consideration of whether or not CPR could be futile, we note that paragraph 4.2 states: “If the senior clinician in charge of the patient, in liaison with the other members of the clinical team, are as certain as they can be that CPR will not re-establish effective circulation and breathing in the patient then CPR should not be offered or attempted.” However, the algorithm on page 10 words the question differently and asks: “Is attempting CPR likely to be clinically beneficial?”

This, in our view, is a key decision point, but it is not clear if the policy is intending patients/families should be offered a choice about CPR or not. Or is the case that the policy is advocating a medical decision be made for applying DNACPR? The implications may well be profound for subsequent actions. It is not clear, for instance, what should happen with a patient who may be unrealistic about wanting CPR, nor what should be determined for a patient who might not want to talk about dying.

We consider that the wording used in the policy is critical, and we are concerned that the differences in wording used in the different parts of this policy will cause significant confusion.

In relation to the issue of mental capacity, we would note that some patients with advanced, terminal illness may well have mental capacity to make decisions, but may either be in denial about the fact they are dying or else may not wish to discuss their death in an open way. This is an issue which is often disregarded, or

¹ [http://www.bbc.co.uk/news/health-27247764](http://www.bbc.co.uk/news/health-27247764)
under-emphasised, in policy making. A recent study by Marie Curie Cancer Care recruited people to talk about terminal illness; even amongst this (non-random) sample, it concluded: “A striking factor in many of our conversations was the extent of denial, either for the person or family.”

All people need hope so, for such patients, an informed decision about CPR may not be possible without brutally forcing information upon them which would cause great distress. A clinician may therefore be required to choose between forcing a distressing conversation on a patient, or accepting the default position for a patient with mental capacity, i.e. for CPR, even though they feel that would not be in the patient’s best interests.

A not-uncommon scenario might be patient of 70 years who has advancing cancer of the bowel with liver metastases, and is relentlessly deteriorating. Judging by the rate of his deterioration such a patient may be estimated by a clinical team to have a few weeks to live.

The patient might well say: “I know it will get me eventually, doc, but I’m not going to stop fighting.” His family might well say: “We understand he is dying, and are prepared for it, but he has never been able to accept it right from the time he was diagnosed. He’s still talking about going on holiday next year.”

In such a scenario, attempting CPR is not likely to be of clinical benefit and, as far as a doctor might be able to ascertain, would not be likely to re-establish effective circulation and breathing. However, if a decision is made to treat such a case as DNACPR as a medical decision, then we would be concerned that such a scenario is not covered well by section 5 of the proposed policy. Should a discussion, for instance, take place with the patient to inform him of the team’s decision? Should a copy of the DNACPR form be handed to the patient (as per the policy)?

If the decision is that CPR is a choice for the patient, and the patient’s initial response is: “Oh yes, I would want to be resuscitated”, we would question how far such discussions proceed to ensure that is an informed decision. Or should the default position be accepted, i.e. for CPR? If so, both the staff who are obliged to administer this CPR and the patient’s relatives may be very distressed by such an ‘inappropriate’ CPR attempt.

We are concerned that until such grey areas are addressed more transparently, we will continue to have policies which clinical staff find difficult to believe in, and which will not prevent further Addenbrookes-type complaints. If the proposed policy is followed to the letter, we are concerned it may result in more inappropriate/distressing conversations with patients, or more inappropriate CPR attempts.

There is therefore a risk that clinical staff will continue not to follow policy, because they consider it does not sufficiently address such ‘real world’ situations. We would note, for instance, that at present there are many cases where DNACPR discussions take place with families but not with patients, even in cases where patients have mental capacity.

BMA Cymru Wales therefore suggests that, before the all-Wales policy is adopted, further thought is given to whether it would be possible to devise a more novel approach that could better deal with scenarios such as the one we have outlined above. Indeed we note that the latest judgment from the Addenbrooke’s judicial review is expected shortly. This may impact on the guidance, e.g. section 4.2, and it may be sensible to wait for that judgement before finalising this policy.

Frequency of reviews of DNACPR status

BMA Cymru Wales supports reviews of DNACPR decisions being conducted when there has been a clear change in the clinical condition of patients. We consider this should be the determining factor in such reviews being conducted, rather than reviews simply being triggered by an arbitrary time frame. We also

suggest that the triggering of a review following a request from a patient, or their advocate, should also involve an element of clinical judgement as to its appropriateness.

Specific comments:

At a UK level, we note as part of a review of the joint stance by the BMA, RCN and Resuscitation Council (UK) on resuscitation decision making, the term ‘DNACPR’ is being replaced by ‘CPR’ in many places to reflect decisions either way. We would suggest that this change the emphasis might also be considered for this all-Wales policy – e.g. in the title, section 4.1, “When DNACPR status is unknown”, sections 4.2–4.5, “DNACPR discussions” and section 7 “Review of a DNACPR decision”. (We would note that this appears to be the approach in the ‘Information for Patients’ leaflet.)

We would suggest that it might be helpful to look at consistency of language – for example, in different parts there is mention of: “restoring”, “restarting”, “maintaining”, “re-establish effective” circulation and breathing, and likelihood “to succeed” and “cannot be successful”. Similarly we note the use of: “those close to the patient”, “those closest to the patient”, “relatives”, “close relatives”, “carers”, “families”, “loved ones” and “close support”. We also note that there has also been some question in discussions on CPR generally on the appropriateness of the term “futile” (see section 5.2a).

Page 5 – reference to Francis may date the policy – how often will it be reviewed? It may be more helpful to replace this with “duties and obligations set by the professional regulators e.g. GMC and NMC”.

Page 5, penultimate bullet point – consider re-phrasing “asked to decide” to “asked their views and wishes”.

Page 6, section 2.3 – this refers to a specific “advanced” decision NOT to initiate CPR – there is no such thing as an advanced decision. This should read “a specific advance decision”.

Page 7, section 4.1 – suggest inserting “initially” presumed (and again at 5.1 and 5.2c).

Page 8, section 4.2 – suggest including “causing distress and” before “adding an unnecessary burden and not providing relief”.

Page 8, section 4.3 – “Depending on the patient’s specific circumstances – the clinician must be aware of the current clinical status, the benefits and risk of harm from CPR.” The first part of this sentence is unnecessary in our view, and does not add anything.

Page 9, section 5.2b – need to include “If the patient’s wishes are not known when they arrest” in third sentence. The start of the sentence refers to the wishes of a single patient, so the last phrase should also refer to the best interests of a single patient and should therefore read “in the patient’s best interests”.

Page 10, “clinically beneficial” should be “re-establish effective circulation and breathing” (or something similar) and why does question 4 “Can an informed discussion take place?” only lead to “CPR” (this is different in the quick reference guide)? With reference to the statement “**** see Para 7.30 MCA (2005) guidance – welfare attorney must be designated to cover life-prolonging treatment decisions and be registered with the office of the public guardian” it is not clear to what in the flow chart this refers.

Page 11, section 5.2c – “advanced decision” should be “advance decision” each time it occurs.

Page 11, audit point 5 – “advanced decision” should be “advance decision”. Suggest changing “arrest call” to “CPR attempts”.

Page 11, section 5.2d – suggest changing “order” to “decision” (also at top of form on page 23). We note there have been criticisms of the use of the term “order” in the past.
Page 11, section 5.3 – suggest removing “never” as this may not always be achievable for legitimate reasons. Same point on audit point 7 regarding all the “musts”, which would be better as “shoulds” to allow for exceptions.

Page 12, section 5.4, second paragraph – skill to do what – make the assessment? Query the inclusion of the term “best interests balance sheet” which has been used by the Court of Protection but not formally in clinical practice. The phrase “matters relating to the patients” should read “matters relating to the patient”. The phrase “clearly recorded in the notes by way of a best interests balance” would read better with a comma immediately following the word “notes”.

Page 13, section 5.5a – would recommend rephrasing “with regard to organ donation should be considered” as “with regard to organ and/or tissue donation should be considered”.

Page 13, section 5.5c – “advanced decision” should be “advance decision” each time it occurs.

Page 14, section 5.7 – “Homes” should not have a capital “H”.

Page 15, section 6.2 – change first “must” to “should”. It would be helpful to explore how this relates to section 4.2 where informing the patient may be unnecessarily burdensome. Also, “patients’ health record” should be “patient’s health record”.

Pages 15-16, section 6.4 – In the first bullet point 1, “patients’ medical record” should be “patient’s medical record”. In the first bullet point 3, “patients GP” should be “patient’s GP”. In the second bullet point 1, “patients GP” should be “patient’s GP”.

Page 17, section 7.3 – with reference to the sentence “The communication must be in writing and logged in all relevant records and contain a copy of the overwritten cancelled original document”, we would point out that not all of the electronic patient records used within Wales have the functionality to accept scanned documents or photos of documents (e.g. Canisc). Therefore it will not be possible to include “a copy of the overwritten cancelled original document” in “all relevant records”.

Page 22, form:

in part 1 should it stress LPA with the relevant authority to make decisions about life–sustaining treatment? Anything done under the authority of a LPA must still also be in the patient’s best interests.

is “NAAD” needed in part 2? Earlier in the document it states NAAD would usually lead to a DNACPR (page 13, section 5.5B). It does not follow that it will always however. The reason for a DNACPR to follow from a NAAD would be “not in best interests/harm from CPR”.

Page 20, section 10.1d – “LHB’s” should be “LHBs”.

Page 23, section 1 – “legal advice” is not always recommended in the policy, and “disagreement” between who? See, for example, in previous section 8.3 it states “legal position must be considered” and in audit point 16 “In exceptional circumstances legal advice may be necessary”.

On the patient leaflet:

the section “Who makes the decision if I can’t?” gives the impression that the patient or someone given the authority “makes the decision” whereas it should be a joint decision.
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