Resuscitation Council (UK)

The Queen on the application of David Tracey (personally and on behalf of the estate of Janet Tracey (deceased))	**Appellant**
– and –	
Cambridge University Hospitals NHS Foundation Trust	**1st Respondent**
– and –	
Secretary of State for Health	**2nd Respondent**
– and –	
Equality and Human Rights Commission	**1st Intervener**
– and –	
The Resuscitation Council (UK)	**2nd Intervener**

1. The Resuscitation Council (UK) [RC (UK)] welcomes the carefully considered judgement, which was undoubtedly difficult and challenging, in this case. The case highlights a highly complex area of medical practice and ethics.

2. The judgement stated that by failing to discuss the making of a do-not-attempt-cardiopulmonary-resuscitation (DNACPR) decision with a patient who had capacity and had expressed a clear wish to be involved in discussions about her treatment, the first defendant was in breach of Mrs Tracey's human rights under Article 8 of the European Convention.

Article 8

Right to respect for private and family life

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The judgement further stated *'there should be a presumption in favour of patient involvement…there need to be convincing reasons not to involve the patient'*.

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The RC (UK) emphasises the importance of clinicians achieving effective communication concerning decisions about cardiopulmonary resuscitation (CPR) with patients and those close to patients (as recommended in the our joint guidance with the British Medical Association and Royal College of Nursing 'Decisions Relating to Cardiopulmonary Resuscitation') and of involvement whenever possible of patients in shared decision-making about their treatment [as also recommended in 'Decisions Relating to Cardiopulmonary Resuscitation', in guidance from the General Medical Council (GMC) and in the NHS Constitution].

The RC (UK) encourages all clinicians who may be required to undertake sensitive discussions and explanations about these decisions to ensure that they have the necessary communication skills, and encourages all healthcare employers to ensure that all relevant clinical staff have access to training to develop and maintain those skills.

3. The judgement stated *'It would probably be impossible to devise a scheme which is completely free from difficulty. The problems generated by decisions whether or not to impose DNACPR notices are inherently fraught. The question whether to consult and notify the patient is inevitably one of the utmost sensitivity and difficulty. Whether it is appropriate to consult will depend on a difficult judgment to be made by the clinicians.'* Whilst stating that a clinician has a duty to discuss a DNACPR decision with the patient the judgement acknowledges that there are some situations in which a clinician thinks that the patient will be distressed by being consulted and that that distress might cause the patient harm. The distress must be likely to cause the patient a degree of harm to warrant them not having the decision discussed with or explained to them.

   The judgement has emphasised that doctors should be wary of being too ready to exclude patients from *'the process'* on the grounds that their involvement is likely to distress them. Many patients may find it distressing to discuss the question whether CPR should be withheld from them in the event of a cardiorespiratory arrest. If the clinician forms the view that a patient will not suffer harm if they are consulted, the fact that they may find the topic distressing is unlikely to make it inappropriate to involve them.

   In such circumstances the RC (UK) emphasises the importance of clinicians documenting clearly their reasons, should they decide not to discuss a DNACPR decision with a patient or explain it to them. The judgement recommends also that the court should be very slow to find that such decisions, if conscientiously taken, violate a patient's rights under Article 8 of the European Convention.

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4. The judgement has confirmed that if a clinician considers that CPR will not work the patient cannot require him/her to provide CPR. It states that this does not, however, mean that the patient is not entitled to know that the clinical decision has been taken.

   The RC (UK) emphasises the importance of clinicians considering anticipatory decisions about CPR as part of delivering high-quality and compassionate end-of-life care for their patients. Clinicians who may be involved in considering such decisions should be familiar with the likely prognosis following CPR in different clinical circumstances in order to

   i. identify those for whom CPR would be ineffective and
   ii. in order to be able to discuss the balance of risks and benefits to those for whom a best-interests decision is needed.

   The RC (UK) believes that making and making clear this distinction is important whenever a decision about CPR is under consideration. It is important that high-quality care for a patient is not compromised by avoidable delay in making a DNACPR decision for a patient for whom it is clear to the healthcare team that CPR would be ineffective and would be an unnecessary and undignified intrusion during the last moments of a patient's life. When a DNACPR decision is made under these circumstances clinicians should explain it to patients and those close to patients at the earliest possible time, unless such explanation is contrary to the patient's expressed wishes or unless they believe that explaining the decision to the patient would be harmful.

   When there is a possibility that CPR could restore the person's circulation and breathing for a duration and/or to a quality of life that the patient would wish to have, decisions about CPR must be made in careful consideration of the person's best-interests and on the basis of shared decision-making.

   The RC (UK) endorses strongly the emphasis in 'Decisions Relating to Cardiopulmonary Resuscitation' that every decision must be based on careful consideration of each person's individual circumstances.

5. In relation to a DNACPR decision the judgement expressed doubt that a doctor is under a legal obligation to offer to arrange a second opinion in all circumstances and found no basis for holding that Article 8 of the European Convention on Human Rights requires him/her to do so. The judgement acknowledged that to offer a second opinion may be part of a doctor's usual duty of care if a patient requests a form of treatment that the doctor considers not clinically indicated. It

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acknowledged also that there is no obligation to offer to arrange a second opinion in a case where the patient is being advised and treated by a multi-disciplinary team all of whom take the view that a DNACPR decision is appropriate.

The RC (UK) endorses previous guidance in 'Decisions Relating to Cardiopulmonary Resuscitation' and that from the GMC that where a DNACPR decision is made on the grounds that CPR will not work, and a patient or their representative does not accept that decision, a second opinion should be offered. Also, in the unusual circumstance in which the doctor responsible for a patient's care feels unable to agree to that patient's request to receive attempted CPR, or where there is a lack of agreement within the healthcare team, seeking a second opinion is recommended.

When a decision about CPR is being considered on a best-interests basis, a second opinion will not usually be needed as the consideration should involve shared decision-making with the patient or their representative(s).

6. The judgement's conclusion that recording a DNACPR decision in a person's health record engages Article 8 of the ECHR appears to uphold the appellant's slightly broader submission that Article 8 is engaged whenever a DNACPR decision is considered because, if a DNACPR decision is made, it is likely directly to affect how the patient will end his or her life.

   The judgement emphasised the clear distinction between engagement of Article 8 and a breach thereof.

   The RC (UK) considers that Article 8 may be engaged and potentially breached also should a clinician not consider an anticipatory decision about CPR with or for a patient who is at clear risk of dying or suffering cardiorespiratory arrest. Failure to consider a decision about CPR or to ascertain the patient's wishes in relation to CPR (or the views of those close to the patient without capacity) may leave such a person at risk of receiving CPR that they would not have wished to have and that could have been avoided had the matter been afforded appropriate consideration and discussion.

   The RC (UK) emphasises the importance of clinicians considering anticipatory decisions about CPR as an integral part of delivering high-quality and compassionate end-of-life care for their

patients. Whenever possible (as recommended in 'Decisions Relating to Cardiopulmonary Resuscitation') such consideration should form part of advance care planning with people who are identified as approaching the end of their life, so that carefully considered decisions can be reached with full involvement of the patient and (where appropriate) those close to them. This will reduce the need for decisions being made in haste when a clinical crisis occurs, often reducing the patient's ability to participate fully in shared decision-making.

7. The judgement stated that the absence of a national policy defining precisely how and when decisions about CPR should be made was not a breach of patients' human rights under article 8. The court had not identified any serious ambiguities in 'Decisions Relating to Cardiopulmonary Resuscitation' (the Joint Statement).

   The BMA, RC (UK) and RCN have reviewed and revised the Joint Statement to take account of developments in clinical practice and in the light of feedback on the current (2007) version. The process of review and revision is nearing completion, and the three author organisations look forward to publishing it in the near future.

Summary

The Resuscitation Council (UK) wishes to promote:

- high-quality practice in making decisions about whether or not CPR is attempted;
- increased use of advance care planning, including making decisions about CPR, as part of high-quality clinical care of people approaching the end of their life;
- effective and timely communication with patients and those close to patients about such decisions whenever possible and appropriate;
- clear documentation of all decisions about CPR and of the reasons for them;
- clear documentation of discussions about such decisions or of the reasons why those discussions were not possible or appropriate.