**The status of ‘Do Not Resuscitate’ ‘Orders’**

*Increasingly care plans of residents in care homes, or patients in hospital contain paperwork pertaining to a decision concerning their resuscitation. This should be completed following consultation with the patient, their family and consideration as to whether the patient has made an advance decision or health and welfare lasting power of attorney. However, the End of Life Care Audit – Dying in Hospital: National report for England 2016 published in March 2016 by the Royal College of Physicians found up to 40,000 patients a year across the country were having the ‘orders’ imposed on them without their families being made aware. This article considers the status of a ‘Do Not Resuscitate’ (DNR) decision and to what extent it interacts with an advance decision or health and welfare lasting power and the importance of consultation*.

DNRs, also known as ‘Do Not Attempt Resuscitation’ (DNARs) and ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPRs) refer to a decision made by medical staff not to attempt cardiopulmonary resuscitation (CPR) if a patient stops breathing or if the patient's heart stops beating. It can take various forms, including the administration of drugs, breathing tubes to open the airway, electric shock therapy, and physical compression of the chest and inflation of the lungs. Watching CPR performed in television dramas is not the same as seeing it performed in the real world: it can result in significant rib fractures, bruising and pain and leave the patient with a poor quality of health and life.

Factors affecting patients' decisions on the withholding of life‐sustaining treatment include acceptance of the inevitable progression of disease, trust towards doctors, a feeling of burden to others, symptom burdens, and the preference to die naturally (Pang S M, Tse C Y, Chan K S. et al: An empirical analysis of the decision‐making of limiting life‐sustaining treatment for patients with advanced chronic obstructive pulmonary disease in Hong Kong, China. Journal of Critical Care). Yet many families see CPR as something which should always be done: it is hard evidence that they have done their part and that nothing more could be done to save their loved one. For many, deciding not to perform CPR means giving up and accepting death.

***The decision not to perform CPR***

The treating medical clinician has the responsibility for deciding whether a particular treatment is or is not necessary and appropriate for the patient. The doctor might consider that resuscitation is likely to be futile and not successful, or the burden of CPR outweighs the benefit to the patient. This will include consideration of the probability of survival, the patient's wish, their previous quality of life and expected quality of life if CPR were performed. The Resuscitation Council (UK) has published evidence-based resuscitation guidelines to set out the interventions and practices that are most likely to achieve successful resuscitation from cardiac arrest, and so conversely where it will be futile or burdensome.

There is no right in law for the patient, their family, carer, attorney, deputy or the court to order how the doctor should treat their patient or require a doctor to administer treatment which that doctor does not consider to be clinically necessary or appropriate (See *R (Burke v General Medical Council* [2006] QB 273 paragraphs 50-55 per Lord Phillips and *Aintree University Hospitals NHS Trust v James* [2013] 3 WLR 1299 paragraph 18 per Baroness Hale). This means the doctor can decide not to perform CPR in the event of lung or heart failure and reflect this decision in a DNR ‘order’, placed on the patient’s records. This may be been made in hospital and follow the patient into the community when they leave hospital or made in the community. The doctor’s decision does not require the patient, their family or their attorney’s agreement.

***The need to consult the patient***

Following the case of*R (David Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors* [2014] EWCA Civ 33 patients have a right to be involved in the decision making process. In the judgment, Lord Dyson, the Master of the Rolls, said at paragraph 53,

“*DNACPR decision is one which will potentially deprive the patient of life-saving treatment, there should be a presumption in favour of patient involvement. There need to be convincing reasons not to involve the patient.”*

He went on to warn at paragraph 54, 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.*”

A patient may be excluded from the process if their doctor reasonably considers involving them would cause them psychological harm, such as severe mental distress over and above what an ordinary person would suffer when discussing end of life care. It is nearly always appropriate to consult with the patient’s family.

The duty to consult involves a full discussion, where practicable, about the patient’s wishes and feelings and is integral to the respect for the dignity of the patient. In practice, families may be left confused when asked what they would like the doctor to do in relation to CPR: leaving families to believe that the decision on CPR is theirs to make. It should be assumed that the question is being asked so that the doctor can undertake a burden versus benefit analysis. Families may find reassurance in the outcome, where an open conversation has occurred, which clearly sets out the factors being considered by the doctor.

In July 2016, Stella Edwards, as her father’s health and welfare attorney, attempted to overturn a DNR decision placed on her father Samuel’s file. 83-year-old Mr Edwards was suffering from health problems associated with the terminal phase of his dementia, including pneumonia, type 2 diabetes, hypertension and cerebrovascular disease that had led to strokes. Having lost her mother to a heart attack she said it had been her father’s wish to receive CPR if he required it, as his wife had. The Court of Protection judge ruled that CPR would be ‘positively harmful.’ One has to wonder why Stella felt she had no choice but to challenge the decision, when her father was in his final stage of life and where CPR would provide him with no real benefit.

Ideally, as a result of the decision, the patient and their family should be left with a clear understanding of the following:

1. What constitutes a DNR decision and how the decision is made.
2. A DNR decision may be appropriate, if the patient is likely to stop breathing or their heart stops, but that this will not affect other treatment decisions.
3. The patient and their family can express their views and listen to the expert medical opinion of their doctor.
4. A decision to not perform CPR should be clearly communicated to the patient, with reasons. As a matter of good practice, where the patient disagrees with the decision, the doctor should offer to arrange a second opinion.

A DNR decision is made and recorded to guide the decisions and actions of those present should the patient subsequently suffer cardiac failure, but it is not a legally binding document. A sample of such documentation is set out below.

***Patient refusing CPR***

Of course, a patient is free to refuse CPR. Lady Hale in *Aintree v James* [2013] 3 WLR 1299 noted at paragraph 19 that,

*“[…]It is not lawful to treat a patient who has capacity and refuses that treatment. Nor is it lawful to treat a patient who lacks capacity if he has made a valid and applicable advance decision to refuse it: see 2005 Act, sections 24 to 26. Nor is it lawful to treat such a patient if he has granted a lasting power of attorney (under section 10) or the court has appointed a deputy (under section 16) with the power to give or withhold consent to that treatment and that consent is withheld; but an attorney only has power to give or withhold consent to the carrying out or continuation of life-sustaining treatment if the instrument expressly so provides (section 11(8)) and a deputy cannot refuse consent to such treatment (section 20(5))*.”

Where the patient with capacity does not want CPR, they may make an advance decision, which will be legally binding provides it complies with sections 24-26 of the Mental Capacity Act 2005. As CPR is clearly life sustaining treatment the advance decision must be in writing, setting out what treatment is not to be provided and in what circumstances, including a clear statement that the patient understands that the treatment is not be given even if it will result in their death. The patient must sign the advance decision in front of a witness, who should also sign their name in the presence of the patient.

Where the patient has made an advance decision, it is vital that they or someone on their behalf draw attention to the advance decision, so the treating clinicians are aware of its existence. Where a properly drawn-up advance decision refuses CPR a healthcare professional who attempts CPR on that patient in full knowledge of the valid advance decision would be at risk of a charge of battery and will not be protected from liability.

***Attorney refusing CPR***

Just as the patient with capacity can refuse consent to having CPR performed, if the patient has appointed a health and welfare attorney under a lasting power and selected Option A in respect of life sustaining treatment, where the donor lacks mental capacity to make health decisions, their attorney can act as their proxy. If the attorney believes it is in the donor’s best interests, they can refuse consent to CPR being performed. This might arise for example, in an emergency where those treating the patient are not fully aware of the patient’s health problems and the futility or burden of performing CPR or where the patient is undergoing an operation and there is a risk of cardiac arrest, but where the specialist clinician is not fully aware of other health care considerations.

Without meaningful and sensitive consultation with families about DNRs, many families may be left traumatised by the outcome, feel distrust in the medical system, and if like Stella Edwards, take the matter to the Court of Protection. Legal professionals working with older people and their families have an important role in advising and supporting them to understand they cannot demand CPR and when a DNR order is appropriate, which can mean the patient has a ‘good death’.

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