

Communicating DNACPR Decisions

R (Tracey) v. Cambridge University Hospitals NHS Foundation Trust & Others
(2014)

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Abstract

Deciding when to withhold CPR is a delicate issue, as is the question of whether and in what way the patient ought to be involved in the decision-making process. This was highlighted by the recent case of R (Tracey) v. Cambridge University Hospitals NHS Trust ([2014] EWCA Civ 822). Here, the Court of Appeal granted a declaration against the Cambridge University Hospital Trust for violating a patient's right to private life, when it failed to involve her in the process of signing a Do Not Attempt CPR notice. In this commentary I argue that the judgment of the Court of Appeal in Tracey is in alignment with UK medical law as a whole, as it addresses the need for respecting the dignity of the patient. I emphasise the need for virtuous conduct rather than detailed policy in the context of DNACPR decisions. I also counter some of the misgivings that have been expressed concerning the consequences of the ruling.

Introduction

Cardiopulmonary resuscitation (CPR) can save lives, such as in cases of sudden cardiac arrest. It is however a violent intervention, frequently causing bruised ribs and other painful complications. Thus, there are situations in a clinical context where CPR is deemed inappropriate because it is believed to be futile or not in the best interests of the patient. Furthermore, even if a prolongation of life is seen as meaningful, which is certainly not always the case, the chance of success is quite low among critically ill patients.

Deciding when to withhold CPR is a delicate issue, as is the question of whether the patient ought always to be involved in the decision-making process. This was highlighted by the recent case of *R (Tracey) v. Cambridge University Hospitals NHS Trust*. Here, the Court of Appeal addressed whether a competent adult's right to private life, under Article 8 of the Human Rights Act 1998, requires that she be involved in the decision to complete a Do Not Attempt CPR (DNACPR) notice. Because around half of the UK population die in hospital with a DNACPR in place, the ruling in *Tracey* has a potentially great impact on end-of-life care in UK hospitals.

* DOI 10.7590/221354016X14589134994018

In this commentary I will argue that the judgment of the Court of Appeal is in alignment with UK medical law as a whole, as it addresses the need for respecting the dignity of the patient. I will highlight parallel judgments regarding the ‘therapeutic privilege’ of doctors, and also emphasise the need for virtuous conduct rather than detailed policy in the context of DNACPR decisions.

The Facts

On 19 February 2011, Mrs Tracey was admitted to Addenbrooke’s Hospital after a road accident that left her immobilised from cervical fracture. Two weeks earlier, Mrs Tracey had been diagnosed with lung cancer, with an estimated life expectancy of nine months. Suffering from chronic respiratory problems, Mrs Tracey was put on a ventilator. About a week later, it was decided that Mrs Tracey should be taken off the ventilator. In connection with this decision, a DNACPR notice was completed by a Dr Lavinio.

Immobilised after the accident, Mrs Tracey nevertheless managed to communicate through writing and whispers. She made it clear that she also wanted to be involved in the more difficult discussions regarding her treatment. During the High Court hearings in 2012, Dr Lavinio claimed to have broached the issue of resuscitation with Mrs Tracey before completing the first notice. The patient, he said, had nodded in agreement.

After being successfully weaned from the ventilator, Mrs Tracey seemed to stabilise. When her daughter became aware of the meaning of the DNACPR order in her mother’s notes she was ‘horrificed’ and communicated this to the medical team. This led to the removal of the first notice on 2 March by Dr Alavi, who also spoke to Mrs Tracey and gathered that she was opposed to the DNACPR decision.

During the following days, Mrs Tracey’s health deteriorated. She was approached concerning the imposition of a renewed DNACPR notice, but refused to discuss the matter. On 5 March a second notice was completed after discussion with members of Mrs Tracey’s family, who agreed that it was an appropriate decision. This second notice was not in question at the proceedings.

On 7 March 2011, Mrs Tracey passed away. Her husband, David Tracey, subsequently made an application for judicial review regarding the decision-making procedure leading to the first DNACPR notice. Mr Tracey claimed that the failure to consult Mrs Tracey or her family members amounted to a breach of her Article 8 Convention rights by the Cambridge University Hospitals Trust. Adding to this alleged breach was the fact that the Trust had not made available its CPR policy to the patient, depriving her of the opportunity to get a second opinion on the decision. A further claim was made against the Secretary of State, for breaching Mrs Tracey’s Article 8 rights in failing to publish national guidance on ‘clear, accessible and foreseeable’ resuscitation decision-making, securing patients’ rights to information and involvement.

At first instance, the judge found that neither Mrs Tracey nor her family had been engaged in the decision to impose the first notice. But because the notice had never been acted upon and later removed, the judge held that the Article 8 claims of Mr Tracey were academic. The family made an appeal which was allowed by the Court of Appeal, leading to the decision that is commented on here.

Holdings

The Court of Appeal decided to grant a declaration against the Trust, holding that it had indeed ‘violated Mrs Tracey’s article 8 right to respect for private life in failing to involve her in the process which led to the first notice’.¹ Though there might be reasons to refrain from consulting a patient regarding CPR, the Trust had not demonstrated that there were any such convincing reasons. Article 8 was found to be engaged, since a DNACPR decision pertains to how a patient passes the closing days and moments of her life and how she manages her death. This, it was held, ‘touches in the most immediate and obvious way a patient’s personal autonomy, integrity, dignity and quality of life’ – values that Article 8 are meant to protect.² The fact that there was no positive right to resuscitation was immaterial to the proceedings, as no such claim had been made.

The Trust had produced an information leaflet on its CPR policy a few months earlier, and so the court found that no declaration was needed that the Trust make its policy accessible. It was also found that the policy was sufficiently clear. As for offering patients a second opinion, in the view of Dyson LJ the issue did not arise on the facts of the case, as there was no disagreement between patient and doctor, or within the medical team. There was also no basis for holding that Article 8 establishes a right to a second medical opinion. The recommendations found in *Decisions Relating to Cardiopulmonary Resuscitation*, also known as ‘the Joint Statement’ – issued by the British Medical Association, the Resuscitation Council and the Royal College of Nursing – were cited as treating the issue in an appropriate way.

As for the claim against the Secretary of State, the court held that requiring the formulation of a unified policy at the national level would amount to an unjustified intrusion into government healthcare policy, which encourages decision-making at the local level. Thus, the Secretary of State was in breach neither of the Article 8 rights of any patient, nor of the 2006 NHS Act. The

¹ At paragraph 88.

² At paragraph 32.

decision of the Secretary of State to commend the guidance of the Joint Statement was found to be sufficient to meet the requirements of Article 8.

Commentary

The central reasoning behind the decision of the court can be found in paragraphs 53 and 54 of the judgment:

[...] since a 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.³

[...]

There can be little doubt that it is inappropriate (and therefore not a requirement of article 8) to involve the patient in the process if the clinician considers that to do so is likely to cause her to suffer physical or psychological harm.⁴ [...] If however the clinician forms the view that the patient will not suffer harm if she is consulted, the fact that she may find the topic distressing is unlikely to make it inappropriate to involve her. [...] I would add 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 Convention.⁵

This reasoning was in disagreement with the corresponding guidelines of the 'Joint Statement' at the time of the proceedings:

When a clinical decision is made that CPR should not be attempted, because it will not be successful, and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate discussion with the patient to explore their wishes regarding CPR.⁶

A generous attitude towards non-involvement seems to have been widespread among clinicians prior to *Tracey*. Research conducted in 2009 suggested that non-involvement of patients in DNACPR decisions was very common, with patients being consulted in less than a third of the cases.⁷ Presumably, a sizeable portion of these would have required consultation under the *Tracey* ruling.

³ At paragraph 53.

⁴ At paragraph 54.

⁵ *Ibid.*

⁶ At paragraph 48.

⁷ J.R. Levin et al., 'Life-sustaining Treatment Decisions for Nursing Home Residents: Who Discusses, Who Decides and What is Decided?', *J. Am. Geriatr. Soc.* 47 (2009), 82.

Motivations for non-involvement may of course vary. Clinicians may sincerely believe that it is not in the best interests of the patient to discuss CPR, due to anxiety or a severely weakened state. But it cannot be ruled out that doctors sometimes wish to avoid the issue in order to avoid complications and a risk of breakdown in patient-clinician relations. The fear of being misunderstood as wishing to hasten the death of the patient, with ensuing loss of patient trust, is understandable. The risk of such misunderstandings were highlighted in the case of *Glass v. UK* (2004), where a DNACPR notice was put in the notes of a child without the involvement of the mother, who believed the DNACPR, together with diamorphine treatment, was part of a plan to euthanise her son (*Glass v. United Kingdom* [2004] ECHR 103).

During the *Tracey* proceedings, the Resuscitation Council, acting as an intervener, submitted that since a futile and potentially harmful intervention cannot be required of a clinician, it would not be necessary in such a case to consult the patient about the DNACPR decision. This reasoning was rejected by Dyson LJ, who argued that:

The fact that the clinician considers that CPR will not work means that the patient cannot require him to provide it. It does not, however, mean that the patient is not entitled to know that the clinical decision has been taken. Secondly, if the patient is not told [...] he will be deprived of the opportunity of seeking a second opinion.⁸

Dr Pitcher, chairman of the Resuscitation Council, also expressed the fear that a presumption in favour of consulting save in exceptional cases 'would seriously hamper the ability of health care professionals to provide individualised and compassionate care for vulnerable people towards the end of their lives'.⁹ Requiring clinicians to consult their patients save in exceptional cases would likely lead, Dr Pitcher feared, to an increase in inappropriate and unsuccessful attempts at CPR.

A similar concern was expressed in the *British Medical Journal* by GP Margaret McCartney, after the judgment in *Tracey* was handed down:

CPR is becoming fetished. Doctors withholding it will have to explain themselves. But doctors who break ribs and bruise lips of terminally ill people, even knowing its futility, will not. Can this really be what patients want?¹⁰

⁸ At paragraph 55.

⁹ At paragraph 92.

¹⁰ Margaret McCartney, 'Is discussing futile treatments really best for dying patients?', *BMJ* 348 (2014), g4180.

Now, it seems clear that the judgment in *Tracey* does not require clinicians to administer CPR against their clinical judgment. Neither are clinicians obliged to always *discuss* CPR with their patients. However, when a DNACPR decision is made, the patient should be *notified* about such a crucial decision, as long as this does not put their well-being at risk. As we have seen, the judgment states explicitly that patients do not have a right to request CPR against the clinical judgment of the clinician. In no way can *Tracey* be read as implying that withholding CPR requires a patient's consent. How, then, might a presumption in favour of consultation and disclosure lead to the undesirable situation envisioned by Dr Pitcher and Dr McCartney?

In her *BMJ* commentary, Dr McCartney objects to an allegedly idealised understanding of the end-of-life situation:

In the real world however, patients present semiconscious and with recent terminal diagnoses; families disagree; and imparting and checking the understanding of information may require days when there are only hours left.¹¹

Dr McCartney seems concerned that clinicians have an obligation to make sure that every terminal patient, with relatives, has a fully informed understanding 'in gritty detail that they will not be offered CPR even though it would be useless'.¹² The fear seems to be that because DNACPR decisions cannot be made without patient involvement, either clinicians will be forced to impart information in a brusque way, or find themselves administering violent and intrusive measures that they know are futile. But this apprehension is not warranted by the judgment.

What the Court of Appeal established was that patients have a right, when possible, to be involved in and notified of DNACPR decisions. The motivation for this is clear: to avoid momentous decisions being taken behind the backs of patients who, like Mrs Tracey, sincerely wish to be involved and notified about the crucial aspects of their care. As the Resuscitation Council's response to the judgment emphasises, the individual circumstances of each patient must determine how the issue of CPR is approached. That DNACPR decisions will sometimes be made without patient involvement is in no way denied by *Tracey*. A more generous reading of the judgment may conclude that it aims at preventing the normalisation of non-involvement of patients in utterly momentous decisions, rather than imposing unreasonable rituals of disclosure.

The principle of withholding information where it is clinically contraindicated, i.e. where there is a risk of the patient's condition deteriorating as a result of the disclosure itself, is traditionally expressed in the so-called 'therapeutic

¹¹ *Ibid.*

¹² *Ibid.*

privilege' of doctors. This privilege is controversial, as it 'allows the doctor's paternalistic concern for her patient's best interests to trump the principle of patient self-determination'.¹³ The therapeutic privilege was however accepted in the case of *Sidaway v. Board of Governors of the Bethlem Royal Hospital* ([1985] AC 871), as a legitimate exception to the clinician's duty of informing a patient of risks inherent to a certain treatment 'if it can be shown that a reasonable medical assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient'.¹⁴

The therapeutic privilege has furthermore been confirmed by the Supreme Court in the post-*Tracey* case of *Montgomery v. Lanarkshire Health Board* ([2015] 2 WLR 768). Here, a physician neglected to inform her pregnant patient about an existing risk of shoulder dystocia (the inability of the infant's shoulders to pass the pelvis) at vaginal birth. In their decision, Lords Kerr and Reid clarified the scope of the therapeutic privilege in the following way:

It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: it is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests.¹⁵

Thus, a suspicion that the patient will suffer harm as a result of making an unwise decision is not enough to justify a therapeutic exception to information disclosure. This arguably harmonises with the decision in *Tracey*, despite the differences in clinical context. While there is no question of consent being needed for a DNACPR notice to be effective, clinicians are not to avoid patient involvement simply on the grounds that CPR is judged to be not in the best interests of the patient. This is, I argue, an appropriate expression of the overarching principle of patient self-determination and keeping patients informed about their treatment, as a matter of respecting the dignity of the patient as a rational and autonomous person.

What remains, then, is the risk of upsetting the patient or causing anxiety at the prospect of not being brought back to life in the event of a crisis. While establishing a strong presumption in favour of involvement and notification, *Tracey* clearly does not sanction inconsiderate or insensitive behaviour on the part of clinicians. The Resuscitation Council, in its response to the *Tracey* judgment, emphasises the need for adequate communication skills in any

¹³ Emily Jackson, *Medical Law: Texts, Cases, and Materials* (3rd edn, Oxford University Press, 2013), 188.

¹⁴ At paragraph 887F.

¹⁵ At paragraph 91.

clinician approaching patients about DNACPR decisions.¹⁶ Likewise, Jo Samanta emphasises the significance of timing:

Although early discussion might be viewed as less distressing emotionally, this could still be inappropriate and sensitive timing will be essential.¹⁷

Premature discussions of DNACPR may interfere with patients' hope, while postponing the discussion may add to the agony of patients and relatives in the dying process.¹⁸ Ideally, the necessary information will be 'given incrementally and guided by the patient's response and feedback'.¹⁹ This of course assumes that there is time for such a gradual approach. In the case of sudden crises, clinicians have only their clinical judgment to fall back on.

It is clear then, that clinicians cannot rely on ready-made models for involving patients in DNACPR decisions. Arguably, the virtues of discernment, compassion and attentiveness are needed; virtues that may not be in place in inexperienced healthcare professionals. As Samanta indicates, the requirements set out by the court may very well lead some clinicians to put off DNACPR decisions until a patient has lost capacity, eager to avoid both the mutual anguish of discussing CPR and the risk of prosecution for deciding without patient involvement. This would of course be an unwanted result of the Court of Appeal's decision.

Conclusion

The self-determination of patients is a guiding principle throughout clinical practice in the UK. DNACPR decisions are unlike other treatment decisions in that they are clinical decisions to withhold treatment, which means that a patient need not consent to the decision for it to be lawful. But the fact that it is a decision to withhold potentially life-saving treatment adds an aspect of finality. It may be the last clinical decision pertaining to the patient. This aspect means that it is entirely inappropriate not to involve the patient in the decision-making process unless there are significant reasons for doing so. Normalised non-involvement would be contrary to the human dignity

¹⁶ Resuscitation Council (UK), 'Preliminary Statement on R (David Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors', June 2014, at paragraph 2, https://www.resus.org.uk/pages/Statements/Statement_Tracey_judgement.pdf, accessed on 30 April 2015.

¹⁷ Jo Samanta, 'Tracey and Respect for Autonomy: Will the Promise Be Delivered?', *Med. Law Rev.* (2015) (Advance Access) 8, <http://medlaw.oxfordjournals.org/content/early/2015/02/24/med-law.fwv003.full.pdf+html>.

¹⁸ *Ibid.* 8-9.

¹⁹ *Ibid.* 9.

of the patient, and violate her right to private life. And it is precisely this right which is protected by Article 8 of the Human Rights Act.

The decision of the Court of Appeal, that there is to be a presumption of involvement of competent patients in DNACPR decisions is therefore to be welcomed. The fact that this presumption is rebuttable only where there is a risk of harm to the patient should not be taken as a concession to paternalistic tendencies. Non-involvement will have to be justified clinically, by 'a reasonable medical assessment' and cannot be motivated by concerns that CPR is not in the best interests of the patient, or that the patient can be expected to oppose the decision.

However, *Tracey* does not do away with the difficult and sensitive nature of DNACPR decisions. The need for highly developed skills of discernment and communication should not, indeed cannot, be circumvented by detailed regulation or policy documents. Hence, the Court of Appeal was right not to require a unified policy on DNACPR decisions from the Secretary of State.

The events in *Tracey* are a reminder of the risk of breakdown in relations between patient and doctor due to failure in communication. This breakdown is especially tragic in the context of end-of-life care. While DNACPR decisions carry with them a risk of breakdown from disclosing as well as withholding information, the decision in *Tracey* rightly affirms the significance of involvement and self-determination in upholding the dignity of the patient.