Chief Medical Officer and Public Health Directorate

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Dear Colleague

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) – CURRENT POSITION

I am writing to draw your attention to the publication on 17 June of the Court of Appeal judgement on a case brought in England against the Cambridge University Hospitals NHS Foundation Trust and the Secretary of State for Health and to provide clarity around the existing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Scottish policy.

The Scottish Government considers that this recent judgement does not fundamentally change national good practice guidance issued in Scotland in 2010. The Scottish *DNACPR Integrated Adult Policy* issued in 2010 can be accessed at

http://www.scotland.gov.uk/Resource/Doc/312784/0098903.pdf

However clinicians need to be aware that the judgement does emphasise and enforce the duty of clinicians to engage in timely, honest and sensitive communication that is truly individualised to meet the patient's needs and situation. Where a clinician or clinical team decides not to inform a patient that a clinical DNACPR decision has been made the only allowable justification for this is now clarified by the judgement below.

The Court clearly sets out that where such a decision is taken "***The clinician has a duty to consult the patient in relation to DNACPR unless he or she thinks that the patient will be distressed by being consulted and that that distress might cause the patient harm***".

From the Acting Chief Medical Officer
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The case clarifies that, when a decision needs to be made re DNACPR, avoiding such a conversation simply because it might cause distress is not an acceptable justification unless the clinical team have judged that the distress would be harmful for the patient. Such a decision should be clearly documented in the patient notes.

This new judgement has relevance for care of patients in every care setting:

1. Where a patient is recognised to be irreversibly and imminently dying there should be sensitive and effective communication with the person and nominated others that this person is expected to die soon. Goals of care and priorities for end of life care must be discussed, agreed and documented including awareness of treatments that will not provide any benefit for the patient such as CPR.

2. In relation to patients who are deteriorating or felt to be at risk of deterioration it remains important to consider in advance whether CPR is a treatment that could or should be offered in the event of an acute collapse with no cardiac output or respiratory effort. However, clinicians must be aware that informing patients of a clinical DNACPR decision out of the context of discussions around goals of care and individualised future care planning can cause anger, confusion and distress for patients and their families. Clinical uncertainties and realistic expectations for current and future care should be sensitively and honestly acknowledged. Opportunities for engaging patients and families in discussions around goals of care and the risks and benefits of different options for future treatment and care must be proactively sought and if specific reasons for not engaging in such discussions do exist (because they might cause harm to the patient) these must be clearly thought through and documented.

It may be helpful to encourage use of the patient information factsheet to support such conversations with patients and families
http://www.scotland.gov.uk/Resource/0039/00398433.pdf.

In July 2013 a DNACPR Indicator was published by Healthcare Improvement Scotland (HIS) (accessible at http://www.healthcareimprovementscotland.org/our_work/person-centred_care/dnacpr/dnacpr_indicator.aspx). This document included a data collection form to allow healthcare providers to record, collect and analyse relevant data to ensure a locally integrated and consistent approach to the implementation of the national policy whilst also enabling improvement in resuscitation practice and anticipatory care planning over time. HIS conducted a first DNACPR Indicator learning session earlier this year and, based on outputs from that session, are now planning a second learning session to ensure that all NHS Boards in Scotland are equipped with the tools and information required in order to collect the data required to measure performance against the indicator and to develop improvement plans.

NHS Board Chief Executives are asked to note this update on the DNACPR, ensure that all clinicians are aware of the Court of Appeal judgement, current Scottish DNACPR Policy and that DNACPR Indicator data is collected, collated and reported locally to inform improvement plans. Work is underway to enable NHS Board data to be collected centrally so that an all-Scotland report can be compiled and published to help facilitate Scotland-wide improvements and help to assure adherence to the Scottish Policy.

The Court of Appeal Judgement can be accessed at http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWCA/Civ/2014/822.html&query=Tracey+and+v+and+Cambridge&method=boolean#disp32

The Resuscitation Council UK (RC UK) response to the judgement will also be helpful to raise awareness with clinicians locally. This can be accessed at http://www.resus.org.uk/pages/statMain.htm#Regina

The General Medical Council is clear that this judgement does not affect its current good practice guidance on CPR within "Treatment and care towards the end of life: good practice in decision-making" (May 2010) accessible at http://www.gmc-uk.org/End_of_life.pdf_32486688.pdf . The newly revised joint statement "Decisions relating to CPR" from the BMA, RC(UK) and the RCN is being finalised and will be released later in the summer.

If you or colleagues have any questions or wish to discuss this further then please contact Professor Craig White, Divisional Clinical Lead, The Quality Unit and Chair of our National Advisory Group in Palliative and End of Life Care at craig.white@scotland.gsi.gov.uk .

Yours sincerely

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