DNACPR ('do not attempt cardiopulmonary resuscitation') orders in patients with a fractured neck of femur who lack capacity

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ABSTRACT

Nationally, half of all deaths occur in hospital, with 94% having a 'do not attempt cardiopulmonary resuscitation' (DNACPR) notice in place at the time of death. Recent court rulings have raised the profile of practices surrounding DNACPR orders where patients lack capacity. Failure to consult with those close to the patient in relation to DNACPR decisions is a breach of the right to respect for private and family life under article 8 of the Human Rights Act.

A report from 2016 found that those close to the patient were not consulted before one out of every five DNACPR orders are placed. We advocate addressing the issue of resuscitation in patients with a fractured neck of femur who are approaching the end of their lives. Where the patient lacks capacity, there is a legal duty to consult with those close to the patient where it is practicable and appropriate to do so. There must be a convincing and well evidenced reason to proceed without consultation, and the orthopaedic surgeon should exercise extreme caution before doing so.

KEYWORDS

DNACPR – Fractured neck of femur – Capacity – Legal – Decision

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Many patients with fragility fractures of the neck of femur have some degree of cognitive impairment, with hip fractures being three times more common in those with a diagnosis of dementia.¹ Early surgery improves outcomes^{2,3} and performing surgery within 36 hours is incentivised financially under the best practice tariff. The General Medical Council (GMC) and the British Medical Association (BMA) advocate advance planning around resuscitation for those at risk of cardiopulmonary arrest.^{4,5} The 30-day mortality rate following a fractured neck of femur is between 8.5% and 10.9%,⁶ making all such patients at relatively high risk. The dilemma is how to make an informed decision about 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders that meets the requirements of the GMC, the BMA and the law while also ensuring that early surgery is performed.

The 2016 Royal College of Physicians audit on end of life care reported that 94% of patients had a DNACPR notice in place at the time of death but in 19% of these cases, this had not been discussed with those close to the patient.⁷ Two recent High Court cases have raised the profile of procedures surrounding DNACPR orders in patients who lack capacity.^{8,9} Both highlight the risk of legal challenge where there has been a failure to follow correct processes. This paper outlines a common clinical scenario and focuses on DNACPR decisions where a patient lacks capacity.

Clinical scenario

A 92-year-old patient is admitted with a fractured neck of femur at 22:00 on a Thursday night. The patient's family assists with providing a history to the on-call orthopaedic junior doctor. The patient has an extensive past medical history including advanced dementia and lacks the capacity to be involved in the decision making process around their care. None of the patient's family members are present on the Friday morning when the admitting team's registrar completes consent form 4 for surgery. The admitting orthopaedic consultant does not countersign consent form 4 as the consultant is unable to make telephone contact with the patient's wife and is in a hurry to get the busy operating list underway. No documentation of the attempt to contact those close to the patient is made and resuscitation status is not addressed.

Owing to the trauma list being full of other patients with hip fractures, the patient does not undergo surgery on the Friday but is handed over to the Saturday on-call team, which reviews the patient at 08:00 on the Saturday morning. The weekend team wishes to address the issue of consent to surgery and a DNACPR decision before starting in theatre as it is clear that the admitting team did not do this. An attempt to contact the patient's family is made to discuss the issue of

consent and the patient's resuscitation status. However, this is not successful and not documented. The 36-hour period in which surgery must be performed to receive the best practice tariff expires at 10:00 on the Saturday morning. Theatre staff are ready to send for the patient. What should the weekend team do?

Discussion

Surgeons frequently make potentially life saving (or prolonging) decisions around relatively high risk surgery for patients who lack capacity. Despite the risk to life associated with a fractured neck of femur, addressing the issue of resuscitation is not universal practice. If the patient has mental capacity, the clinician can explore the patient's views directly and use them to inform the decision making process around DNACPR orders. Nevertheless, patients with a fractured neck of femur commonly lack capacity and if resuscitation status is not discussed with those close to the patient, problems can then arise.

The National Cardiac Arrest Audit reports on the number of in-hospital CPR attempts that achieve a return of spontaneous circulation (ROSC) for a period of more than 20 minutes and of those that result in survival to the point of hospital discharge (45.0% and 18.4% respectively for the period 2011–2014).¹⁰ The chances of survival to hospital discharge reduce dramatically with increasing age.

Specific data relating to in-hospital CPR in patients with a primary diagnosis of a fractured neck of femur do not exist but their frailty means outcomes are likely to be less favourable. In the period immediately following resuscitation, many patients will require admission to an intensive care unit.¹¹ In the context of an elderly patient with a fractured neck of femur, it may be possible to achieve a ROSC following CPR but continued organ support might be considered inappropriate. This makes the decision to perform CPR even more complex.

Who should be the decision maker?

The GMC and BMA state that the responsibility for decision making with regard to DNACPR orders rests with the most senior clinician responsible for the patient's care.^{4,5} The GMC guidance notes that you 'must seek advice or a second opinion from a colleague with relevant experience [if] you are in doubt about the range of options, or the benefits, burdens and risks of a particular option for the individual

patient'.⁴ A decision surrounding CPR should factor in the likely need for (and success of) high level organ support after resuscitation. These are not areas in which the orthopaedic surgeon will have the necessary training and experience. As a result, input from a senior anaesthetist responsible for patient care during surgery should be sought as part of the decision making process around DNACPR notices and the anaesthetist's input should be clearly documented.

How should decisions about DNACPR orders be reached?

The Mental Capacity Act 2005 (MCA) permits treatment to be provided to those who lack capacity only if the treatment is reasonably believed to be in the patient's best interests. In determining this, regard must be given to what is commonly referred to as the 'best interests checklist'. Consultation should take place with the individual listed in that checklist (Fig 1). The views of those close to the patient are therefore important when making any treatment decision (including DNACPR decisions) for those who lack capacity. This is reiterated by the GMC, which states: 'In making decisions about the treatment and care of patients who lack capacity, [...] you must also consider the views of people close to the patient.'¹²

In conducting these consultations, it is important that all are clear that the role of those close to the patient is to help inform the decision making process rather than being the decision maker (unless they have relevant power under an applicable power of attorney). More specifically, in the context of the MCA, the purpose of consulting with those close to the patient is to use their personal knowledge of the patient to assist the decision maker in identifying what the patient would likely have decided had they had the capacity to make their own decision. In the clinical scenario outlined above, the patient's family had been present during the admission process and was involved in the history taking process. However, neither the admitting nor the weekend operating orthopaedic consultant surgeons met with those close to the patient or discussed with them the issues of treatment and resuscitation status.

In these circumstances, the views of those close to the patient on the likely treatment decisions that will be required should be sought on admission wherever possible. Where this has not been possible, clear documentation of the attempts to contact those close to the patient should be made. Doctors should be cautioned against concluding too readily that it has not been practicable to consult with those

People who should be consulted when determining best interests (if practicable and appropriate to do so):

- Anyone named by the person as someone to be consulted on the matter in question or on matters of that kind
- Anyone engaged in caring for the person or interested in his or her welfare
- Any donee of a lasting power of attorney granted by the person
- Any deputy appointed for the person by the court

Figure 1 Extract from best interests checklist from section 4 of the Mental Capacity Act 2005

close to the patient. As demonstrated by the cases of *Tracey* (Fig 2) and *Winspear* (Fig 3), failure to undertake appropriate consultation where there is sufficient opportunity to do so runs the risk of legal challenge.^{8,9}

In reaching his decision in the *Winspear* case, the judge, Mr Justice Blake, noted that section 4 of the MCA states that the decision maker 'must take into account, if it is *practicable* and appropriate to consult them, the views of [...] anyone engaged in caring for the person or interested in his welfare'.⁹ The judge commented that he could 'see every reason why a telephone call at 3.00am may be less than convenient or desirable than a meeting in working hours, but that is not the same as whether it is *practicable*'. Furthermore, he stated: 'The fact that there was no cardiac arrest before the notice was cancelled is not decisive.'

The judge added: 'In the case of persons who lack capacity, the MCA spells out when and with whom a decision taker must consult; if it is not "*practicable* or appropriate" to consult a person identified in s.4 (7) before the decision is

made or acted on, then there would be a convincing reason to proceed without consultation. If, on the other hand, it is both *practicable* and appropriate to consult then in the absence of some other compelling reason against consultation, the decision to file the DNACPR notice on the patient's medical records would be procedurally flawed. It would not meet the requirements of s.4(7) MCA; it would accordingly not be in accordance with the law.'⁹

It is therefore crucial for doctors to be able to demonstrate that their decisions (including those in relation to DNACPR orders) are compliant with the MCA. This includes the need to ensure active steps are taken to consult with those close to patients who lack capacity at every *practicable* opportunity. The circumstances in which consultation will be considered impractical or inappropriate will be limited.

When should DNACPR decisions be made?

The common scenario of a patient with a fractured neck of femur who lacks capacity represents an additional challenge

Mrs Tracey sustained a serious cervical spine fracture during an accident. She was admitted to a critical care unit and placed on a ventilator. Mrs Tracey had a diagnosis of terminal lung cancer and an estimated life expectancy of nine months. A DNACPR notice was completed in case there was a cardiorespiratory arrest while weaning Mrs Tracey off ventilation. Neither Mrs Tracey nor her family were consulted or involved in this decision. When Mrs Tracey's condition improved and she was successfully weaned from the ventilator. On becoming aware of the DNACPR order, Mrs Tracey's daughter raised objections and the notice was subsequently cancelled.

Following deterioration in Mrs Tracey's condition, her resuscitation status was revisited. Mrs Tracey confirmed that she did not wish to take part in discussions on this issue. The clinical team consulted her family, who agreed that a second DNACPR order should be placed. Mrs Tracey died two days later. Following her death, a claim was brought that the trust had breached Mrs Tracey's rights under article 8 (right to private and family life) of the European Convention on Human Rights on the grounds that it had failed to consult with Mrs Tracey or those close to her in relation to the first DNACPR notice. The court found against the trust.

Figure 2 Tracey v Cambridge University Hospitals NHS Foundation Trust⁸

The patient was 28 years old, and had cerebral palsy, epilepsy and spinal deformities. He had lacked capacity since birth. He was admitted with a chest infection at 21:00. At 03:00 the following morning, the medical registrar placed a DNACPR order on the patient's medical records. This was precautionary as there was not felt to be an immediate threat to life but it was done without consulting any family members. The registrar confirmed that he did not think it necessary or appropriate to phone the patient's mother at that time in the morning and it was his intention to arrange for the DNACPR decision to be discussed with the patient's mother later that day. The patient's mother strongly objected and the DNACPR notice was voided.

The patient's mother brought a claim arguing that placing a DNACPR order for a nine-hour period without having consulted with those close to the patient was an unjustified breach of the patient's right to private and family life. The judge found against the trust, confirming that there had been a breach of the patient's article 8 rights.

Figure 3 Winspear v City Hospitals Sunderland NHS Foundation Trust⁹

in the decision making process around DNACPR orders. Those close to the patient are not usually present during the morning ward round when the consultant orthopaedic surgeon reviews the patients admitted to hospital during his or her period on call for the first time. We therefore advocate that discussions take place on admission where possible and/or that those close to the patient are asked to be present during the morning ward round in cases of a fractured neck of femur where the patient lacks capacity. This would allow a face-to-face discussion not only around resuscitation status but also around the proposed surgery.

Where attendance of the family is not possible, the message from the *Winspear* case⁹ should nevertheless be kept firmly in mind: there is a duty to consult with those close to the patient where it is practicable and appropriate to do so. There must be a convincing and well evidenced reason to proceed without consultation, and the orthopaedic surgeon should exercise extreme caution before doing so.

While it may not be desirable for such discussions to take place by telephone, this does not mean that consultation is inappropriate or impractical. Similarly, where a delay in proceeding with surgery to allow for consultation with the patient's family would not significantly adversely impact on the patient's condition, it is unlikely that such delay would render consultation impractical or inappropriate. If the surgeon is of the view that treatment he or she considers to be in the patient's best interests cannot wait and evidence can be presented (on good grounds) that it was not practicable or appropriate to consult with those close to the patient, provision of that emergency treatment will be lawful (assuming all other provisions of the MCA have also been met).

In such circumstances, there should be a clear plan in place to ensure that the decisions made are explained and discussed with those close to the patient at the earliest practicable opportunity. When making decisions about CPR, if there is a prospect that this treatment would be successful and

consultation with those close to the patient has not been possible, extreme caution should be exercised in reaching a view that CPR would not be in the patient's best interests. This is because the views of those close to the patient are an important component in the assessment of best interests and where there is doubt, the balance lies in favour of preserving life.

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