Decision support for doctors in the context of stretched resource: in conversation with Dr Chris Danbury (Webinar 21 May 2020): follow up

Questions we did not have the time to address

LPAs

A good way of framing the discussion in relation to the potential for an attorney to be 'frozen' was suggested by one delegate: i.e. that an LPA **empowers** an attorney to decide, but it does not **require** the attorney to do so?

If an attorney does not feel able to decide (after appropriate support has been provided), then decision-making follows the process set out in s.5 MCA. It does not require automatic referral to court for the appointment of a deputy (and note that a deputy can never **refuse** life-sustaining treatment). When consideration needs to be given to going to court is set out in this guidance from the Vice-President of the Court of Protection: https://www.bailii.org/ew/cases/EWCOP/2020/2.html.

Decision-making support for clinicians

In particular in situations where clinicians feel that they are being asked to make decisions about individual patients in a context of stretched resource, it is important that more junior clinicians are able readily to access decision-support. That can be in the form of more senior clinician, or access to a decision-support forum within the Trust (which may or may not be constituted as part of an ethics forum). Resource decisions are never completely clinical decisions. It is essential that the management structure of the hospital is involved in this type of decision proactively. This may be through the clinical director or other senior clinician with formal management responsibility.

Advance care planning and the role of ReSPECT

A ReSPECT document is a very helpful document in terms of setting out recommendations for treatment at the point where they might be required. By definition they are likely to be of most relevance in the case of a potentially urgent decision. Whether an IMCA would be required under s.37 MCA when a ReSPECT document has been completed will depend upon whether the criteria under s.37 are met – in particular whether the individual is 'unbefriended.' Given the urgency of many decisions in ICU, the likelihood is that, often, it will simply not be possible to instruct an IMCA (i.e. in legal terms, s.37(4) MCA applies).

Admission to hospital

A question was asked as to whether there had been more rapid admission to hospital from care homes, ICU capacity would been overwhelmed. This is an important counterfactual, to which an answer is likely to be all but impossible to give with accuracy, but one anticipates will be the study of study in the years to come.

A follow up question here was as to how the NICE clinical frailty tool came to be treated as an eligibility tool (for hospital / ICU not being clear from the question). The question raises important issues about the communication to (1) medics (in different settings); and (2) the general public about the use of clinical guidance.

As discussed, physical frailty is an important part of the matrix of decision making as this is one of the variables that informs the likely outcome after recovery. As an individual becomes more frail, the likelihood increases that they will require a significant increase in aid with activities of daily living following recovery from critical illness. This does not preclude multiorgan support, but does inform the decision makers to allow the correct individual decision.

Resources

Clinical

Ethicus I: https://jamanetwork.com/journals/jama/fullarticle/197049

Ethicus II: The full Ethicus II paper is still in preparation. The comparison paper can be found here https://jamanetwork.com/journals/jama/fullarticle/2752581

ICNARC data about critical care: https://www.icnarc.org/

The Conflicus study: conflict in critical care:
http://www.atsjournals.org/doi/abs/10.1164/rccm.200810-1614OC

Sarah Wake: Post-traumatic stress disorder after intensive care:
https://www.bmj.com/content/346/bmj.f3232.abstract

David Aaronovitch's experiences in ICU:

- https://www.youtube.com/watch?v=AJI7huIND4g
- https://www.thetimes.co.uk/article/my-nightmare-in-hospital-ptb9rnb6drk

Legal

Useful guidance as to best interests decision-making in the clinical context (going more broadly than just CANH decision-making) can be found here: https://www.bma.org.uk/media/1212/bma-canh-appendix-1-of-full-guidance.pdf, with an infographic here: https://www.bma.org.uk/media/1211/bma-canh-best-interests-decision-making-infographic.pdf

For resources on the MCA and COVID-19, see Alex's page here:
https://www.mentalcapacitylawandpolicy.org.uk/resources-2/covid-19-and-the-mca-2005/
The 39 Essex Chambers Court of Protection team produces case summaries, guidance notes and a (free) monthly Report, all available here: https://www.39essex.com/resources-and-training/mental-capacity-law/

Advocacy

Jakki Cowley: Life, Death and the Journeys in between (Jakki Cowley, Empowerment Matters, 2020, paperback, £15.50): see also Alex's 'shedinar' series conversation with her:
https://www.mentalcapacitylawandpolicy.org.uk/the-shedinar-series-the-imca-conversation/

And a plug for mediation (particularly the Court of Protection Mediation pilot)

Which we didn't get time to discuss: https://www.courtofprotectionmediation.uk/