

The 'do not resuscitate' decision: guidelines for policy in the adult

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The Royal College of Physicians of London, along with a number of organisations, has considered the policy for 'do not resuscitate' (DNR) orders in relation to cardiopulmonary resuscitation (CPR). On the basis of current attitudes towards the more active involvement of patients in such decisions—advance directives (living wills)—and the usual approach in the UK of seeking the views of relatives or next of kin, general guidelines have been drawn up which take into account the results obtained with CPR. The guidelines encompass only the broad principles, as it is envisaged that each hospital or unit will require a more detailed policy according to local circumstances and facilities. Children have not been included because of the special considerations that relate to neonatal resuscitation and the consents required.

Background to policy

The overall results of CPR in severely ill patients need to be considered when drawing up guidelines for resuscitation and DNR orders. Typical figures reviewed by Westwood *et al* [1] include a 12% survival rate for one month and a 14% discharge rate from hospital. In each of the series quoted a substantial number, usually about 50–60% of cases, failed to respond to the initial resuscitation efforts. Many authors have drawn attention to the large proportion of patients in whom resuscitative efforts were inappropriate and unjustified. One report, quoted by Baskett [2], of a seven months study of hospitalised patients who received cardiopulmonary resuscitation, quotes an incidence of 25% of cases in which resuscitation merely prolonged the process of dying. Of the 71 patients in the study group, 29 were successfully resuscitated but nine of them died within 24 hours; and of the 20 patients surviving more than 24 hours, six remained comatose until death.

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Certain groups do badly after CPR: for instance, none of 58 patients with pneumonia survived [3] and in two series of elderly patients, although 31% and 22% responded to resuscitation efforts, none in the first series and only 1.6% in the second could be discharged home [4,5]. In special circumstances it may be justified to make one attempt at CPR in an apparently hopeless case, but efforts should not be continued beyond a reasonable trial period. John Saunders, writing in a recent editorial, referred to the indiscriminate use of CPR as follows: 'if the expected outcome is death, a procedure less dignified and peaceful could hardly be devised' [6].

All hospitals need to have a defined policy for DNR orders and a yearly audit of this important clinical area should be carried out to ensure the appropriateness of the guidance given. The deficiencies that can exist with respect to the recording of DNR decisions were shown in the study by Stewart *et al* [7] in which the medical and nursing notes of all 170 inpatients in nine medical wards were surveyed on a particular day in 1989. A DNR decision had been made for 57 patients, but the decision was documented in both the medical and nursing notes in 26 cases only.

The pattern for DNR orders adopted in the USA with attendant legislation in which patients or their relatives have a considerable input, and which are often considerably influenced by the patients' own appraisal of the quality of their lives may not be appropriate for the UK at present. Not only are there potentially harmful effects of a 'do not resuscitate' order on the patient's attitude and enjoyment of the remaining months of life during a terminal illness, but also relationships within the family may be made more difficult if the decision is made their final responsibility. The effects of such decisions on patients and their families, the whole area of living wills and most recently the appointment of surrogates to make decisions on the patient's behalf, have been the subject of a number of papers in the USA [8–10] and in this country [11,12]. Predictions of outcome, even in apparently terminal conditions, may not always prove correct, and this can lead to further difficulties within the family and may even have medico-legal consequences.

A detailed listing of specific medical conditions for which DNR orders would be particularly appropriate should be avoided as far as possible in view of the many exceptions that occur in clinical practice. Most of the conditions are likely to come from within the following main categories of disease: terminal metastatic disease, severe cardiorespiratory failure,

advanced cardiovascular disease, cerebrovascular disorders with severe stroke, and dementia, including patients with advanced Alzheimer's disease. In making DNR decisions in the elderly it is important not to miss an underlying depression, treatment of which could change the patient's attitude to living.

DNR decisions are but one part of the approach to treatment of a particular case, and taking such a decision does not preclude continued appropriate treatment and care, for instance rehabilitation in a severely incapacitated stroke patient, or even for a malignant disorder. In general, an agreement to CPR is integral to a decision to transfer a patient to an ITU but this should always be verified for the individual patient by the physician before or at the time of the transfer.

Guidelines for DNR order

1. In most circumstances taking a DNR decision should depend upon an assessment by the consultant or senior registrar in charge with other members of the medical and nursing staff who are directly involved in the case of the particular patient. If there is any doubt within that group as to the rightness of such a decision then it is the responsibility of the consultant or senior registrar to seek further medical opinion at senior level, and if there is any remaining disagreement the matter will need to be referred to the clinical or unit director. A decision should be made within 24 hours of the patient being in a situation that could require CPR.
2. In exceptional circumstances, such as within the first 24 hours of an emergency admission for nursing care of a patient with terminal metastatic disease or a severe stroke, and a senior opinion may not readily be available. The decision will then have to be made by more junior staff. That decision is to be reviewed with senior staff at the first opportunity.
3. If the patient had spontaneously expressed a view with respect to resuscitation, this should weigh heavily in the doctor's decision. Similarly if the patient's relatives had raised the matter then their views should also be taken into account. These should not be considered as overriding since the doctor's primary responsibility is to the patient and circumstances are conceivable in which the patient's best interests and the relatives' views are at variance.
4. When the views of the relatives are not already known, the consultant in charge should, wherever possible, seek to obtain this information. One situation when this is particularly important is where the patient has become too ill to express a view, although it is known that he or she would have wanted to. In this case the question to the relatives is best asked in the format 'what do you think he/she should have liked if he/she had been able to tell us?'. In eliciting the family's and patient's views it is important to ensure that they have a reasonable knowledge of what CPR involves and what the likelihood of a successful outcome is.
5. A categorical DNR order should be recorded in the patient's notes along with the reasons for that decision. The decision should be regularly reviewed at intervals appropriate to the underlying illness, in most instances at least weekly. This should be recorded in the clinical notes along with detailed reasons if there are any changes in the decision.

References

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