Making do not attempt resuscitation decisions: do doctors follow the guidelines?

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When do not attempt resuscitation orders are contemplated, guidelines exist to outline standards for planning patient care and decision making. These guidelines may not always be fully followed as ethical issues arise which may prevent doctors from doing so.

INTRODUCTION

Cardiopulmonary resuscitation (CPR) was introduced in 1965 and since then its use has widened, often to situations for which it has been shown to have little benefit.

The joint British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing guidelines *Decisions Relating to Cardiopulmonary Resuscitation* (British Medical Association, 2001) were produced with the purpose of outlining legal and ethical standards for planning patient care and decision making in relation to CPR.

Specifically, the guidelines acknowledge that it is essential to identify patients for whom cardiopulmonary arrest represents a terminal event in their illness, and in whom attempted CPR is inappropriate, as well as identifying patients who do not want CPR to be attempted and who competently refuse it.

It is suggested that it is appropriate to consider making a do not attempt resuscitation (DNAR) order when:

- Attempting CPR will not restart the patient's heart and breathing
- There is no benefit in restarting the patient's heart and breathing
- The expected benefit is outweighed by the burdens.

The joint statement provides guidance with regard to the process of making decisions in this area. This includes what discussions should take place, who should be involved in them, as well as specific details on how such decisions should be documented in patient case notes.

Despite the guideline's recommendation that DNAR decisions should be discussed with patients, it could be argued that doing so forces patients to confront the inevitability of their fate (with negative consequences). It also forces patients to make a choice, when in reality they have no choice, and perhaps goes against the medical principle of 'first do no harm' (Manisty and Waxham, 2003). Finally, patients may have an unrealistic appreciation of the consequences of resuscitation as there is a very optimistic and unrealistic lay view of potential success of CPR. In reality, survival to hospital discharge post-cardiac arrest is 15% at best (Hayward, 1999).

Conversely, it can be argued that poor communication leads to poor patient satisfaction, that CPR discussion is as important as that of any other treatment, and that silence or incorrect information heightens fear, anxiety and confusion of patients and families (Higginson, 2003). In addition, doctors have been shown to be inaccurate in predicting the views and wishes of patients (Hayward, 1999; Higginson, 2003).

The purpose of this study was to evaluate the implementation of these guidelines in clinical practice and explore the reasons why doctors may find the guidelines difficult to follow.

METHODS

A sample of 58 patients on a medical ward in a teaching hospital were audited to evaluate:

- Whether a DNAR statement had been documented
- If no such decision had been made, and in the patient's clinical condition at that time, would CPR have been appropriate for that patient?
- If a DNAR decision has been made, did the case note documentation reflect principles and standards set out in the joint guidelines?

For the basis of the audit any discussions or decision process not documented were assumed not to have taken place. Specifically, the following points were evaluated:

- Were the prior views or advanced directive of the patient known and were these respected?
- Was resuscitation discussed with the patient, or if it was clear from preliminary discussion that the patient did not wish to discuss, was this documented? It was noted if it was not possible for the patient to be involved in such decisions, e.g. because of coma or advanced dementia
- Was resuscitation discussed with the relatives? It was noted if it was not possible to discuss with the relatives, e.g. if they were unobtainable
- Did the case notes reflect whether the consultant responsible for the patient's care was aware and approved of the DNAR decision?
- Was the DNAR statement clearly documented and dated?
- Was the DNAR decision made (but not necessarily documented) by the most senior member of the team available?
- Was the decision recorded in the nursing notes?

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- Were reasons for the decision noted?
- Was reference made to whether further active treatment should be given, e.g. 'for full active treatment but not for CPR'?
- Was the decision written as 'not for attempted CPR' or similar; but not 'not for 2222' – the telephone dialing code to initiate a cardiac arrest call – or 'not for resuscitation' (NFR)?
- Was a reference made to reviewing the DNAR decision and, if so, was it reviewed?

RESULTS

A total of 58 patients were included. The male to female ratio was 31:27 respectively with an average (mean) age of 72.31 years (median 75.5 years, mode 79 years, range 22–95 years).

From the total sample of 58 patients, CPR was felt inappropriate in 27 cases. Out of these 27, a DNAR decision was documented in 14 cases, i.e. in patients where CPR was inappropriate a DNAR order had been made in only 52% of cases – in the opinion of the individual medical team looking after each patient, it was felt that CPR would be inappropriate in 13 of the 44 patients (30%) in which a DNAR decision had not been made.

Reasons that were given for not considering documenting a DNAR decision were:

- Personal difficulties doctors experience when discussing such issues openly with patients
- Lack of discussion from senior members of the medical team to prompt documenting these issues on consultant ward rounds
- Most commonly it was felt that while resuscitation may be indisputably inappropriate for a patient, unless the patient's condition had reached the point where resuscitation could imminently be required, resuscitation status would not be part of the routine appraisal of the patient on a daily basis.

Of the 14 patients where a DNAR decision had been documented, the decision was made by a senior member of the team (100% of cases), clearly documented, legible and dated in the case notes (often underlined or highlighted) in 96% of cases and communicated with nursing staff (as indicated by documentation in the nursing notes) in 93% of cases.

Commonly, reasons for the decision were given (93%), and it was clearly indicated in 77% of the notes that the consultant was aware of, and agreed with, the decision.

The patient, however, was rarely involved in any discussion (only 10% of cases) and family were involved in 36% of cases (this takes into account the situations where patients were unable to be involved, e.g. because of dementia or family members unavailable or not contactable).

Reasons for not discussing the decision with patients and their families were again often related to the individual difficulties the doctor felt when discussing sensitive issues; that discussing the decision would not be of positive benefit to the patient (and may in fact be harmful) and that discussion with family had been intended but not undertaken (although an unsuccessful attempt to contact and discuss with family was rarely documented in the case notes and the above figures may therefore be unrepresentative).

Documentation relating to any active treatment the patient should receive was clarified in just over one third of the cases (36%) and whether and when the decision should be reviewed was never documented in the case sample studied.

Furthermore, the wording was not always recorded as 'not for CPR' or similar. Abbreviations were used such as 'not for 2222' and 'NFR'. This is discouraged in the guidelines in order to avoid any confusion over what is intended and interpreted from the case notes. Equally, a decision not to attempt resuscitation only applies to CPR and there is not always clarification from the case notes about whether the patient should otherwise receive active treatment (only 5 of the 14 notes reviewed). In the absence of any such documentation a policy to actively treat should be assumed.

DISCUSSION

These results highlight two common issues in respect to making resuscitation decisions that have been reflected in other published data on this subject (Biswas et al, 2003). First, in identifying and documenting DNAR decisions for patients in whom CPR would be inappropriate and, second, discussing resuscitation decisions with the patient.

In only approximately half of cases where patients in whom CPR was deemed to be inappropriate had a DNAR decision been made. Clearly a proactive approach is important to avoid unnecessary and inappropriate resuscitation attempts.

Equally, it is much more preferable for the team looking after a patient to discuss and document resuscitation status as part of the patient's management plan, rather than the medical team providing cover out of routine hours being asked to address the issue as and when a patient's condition deteriorates.

Patients' relatives are not always involved in decisions relating to CPR, and while it should be noted that although relatives have no legal status in terms of actual decision making, it is good practice and recommended to involve people close to patients in decisions.

The patient is rarely, if ever, involved in any resuscitation decisions despite evidence from their case notes that they have been otherwise very actively involved in management plans. The involvement of patients in discussion about resuscitation decisions is a contentious issue and there is an argument for and against discussing resuscitation with terminally-ill patients. Clearly this involves a balance of the ethical principles of a desire to do good, not to do harm and respect for patients' autonomy.

Improving the prevalence of documented DNAR decisions in hospital case notes may be achieved by greater awareness of the guidelines and distribution of the individual hospital protocols for resuscitation decisions to doctors on induction, with additional availability at a ward level.

Perhaps resuscitation status should form part of the initial clerking and subsequent consultant review of the patient on arrival to hospital. It is suggested that communication about DNAR orders may be improved if they are discussed with the patient within the context of treatment plans, rather than as a separate area of discussion (Reid and Jeffrey, 2002). Patients and doctors may find these discussions less imposing if the issues are discussed openly at an early stage when the patient is not at a point of critical illness or has reached a terminal diagnosis.

Clearly there will be patients who have reached this point on arrival to hospital and equally decisions need to be revisited as circumstances change (regular review of resuscitation decisions forms a core recommendation of the current guidelines).

Finally, standardized proformas are now being increasingly introduced for the documentation of admission clerking and post-admission consultant ward rounds (Thompson et al, 2004). Including resuscitation status as a section in such proformas provides a prompt for junior and senior doctors to consider and document resuscitation status as part of their management plan.

CONCLUSIONS

The subject of CPR presents personal and professional dilemmas for doctors making such decisions; however, an initial assessment and realistic communication with patients and their relatives is essential if inappropriate resuscitation attempts are to be avoided. HM

Conflict of interest: none.

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KEY POINTS

- Cardiopulmonary resuscitation is not always appropriate for all patients.
- It is essential to identify patients for whom cardiopulmonary arrest represents a terminal event in their illness and in whom attempted cardiopulmonary resuscitation is inappropriate.
- It is recommended that doctors should discuss resuscitation decisions with patients. This is not commonly practiced, and the basis of this recommendation is a contentious issue.