Where now with Do Not Attempt Resuscitation decisions?

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Abstract

Geriatricians are often asked to make decisions about withholding cardiopulmonary resuscitation. This seems to be becoming more difficult and more controversial. There has been increased public concern about this subject recently and a recognition within the profession of the need for more openness and transparency in decision making. The implementation of The Human Rights Act led to updated guidelines from professional bodies, but these are likely to need careful interpretation in light of local circumstances before they can become a practical tool for decision making.

Keywords: resuscitation, DNAR, ethics

Introduction

The British Medical Association (BMA) has produced new guidance for Do Not Attempt Resuscitation (DNAR) decisions which differs significantly from previous advice. British geriatricians will wish to ensure that elderly patients who are likely to benefit from cardiopulmonary resuscitation (CPR), and want it, actually get it, whilst those who will not benefit, or do not want it are allowed to die with appropriate dignity. We should be aware that this is an issue of considerable sensitivity for patients and their relatives, as well as all health professionals.

We hope to highlight the changes in the guidance, discuss the issues raised and help British geriatricians to interpret them in a practical way. We have written with the acute hospital and rehabilitation settings in mind, rather than more specific settings such as a hospice or nursing home. We have not addressed the special circumstances of children and young people although we are aware that some geriatricians care for young disabled or younger general medical patients. Statements that were specifically made in the guidance are in bold text and the remainder of the text represents our interpretations and comments.

Background

The BMA [in conjunction with the Royal College of Nursing and the Resuscitation Council (UK)] produced an updated set of guidelines on decisions relating to CPR in March 2001 [1]. These came less than 2 years after the previous guidelines and were significantly different [2]. They are suggested as a basis for local policies, with modification to take account of local circumstances and facilities. The Department of Health had already issued a circular on this subject, following adverse publicity the previous year, requiring all NHS Trusts to have resuscitation policies in place by April 2001 [3].

The most immediate reason for the update was the implementation of the Human Rights Act in late 2000, incorporating most of the European Convention on Human Rights into UK Law. Separate BMA advice has been issued on the likely effects of the Act on medical decision-making [4]. The Act regulates the relationship between individuals and public authorities and it is clear that under it doctors are likely to be considered public authorities. The BMA has emphasised that the Act enshrines in law many of the practices which would previously simply have been considered good medical practice. It seems that, under the Act, doctors are likely to have to be more aware of their obligations to ensure that medical decision making is transparent, that they can justify their decision making and that they can show that they have taken the Human Rights of the patient into consideration.

Several of the articles of the Act may pertain to DNAR decisions. The right to life (article 2) and the right to freedom from inhuman or degrading treatment (article 3) may affect decisions that either deprive an
individual of life sustaining treatment or subject them to treatment without benefit. The right to respect for privacy and family life (article 8) will be relevant to the extent to which patients should be involved in decisions, the amount of information provided to them and communication with the friends and relatives of both competent and incompetent adults. The right to hold opinions and receive information (article 10) is relevant to patient involvement in decisions. The right to be free from discriminatory practices (such as ageism) is covered by article 14.

An additional reason for new guidelines may have been growing concern about the DNAR process in British hospitals. Age Concern has publicised cases on its website which it alleged demonstrated ageism [5]. The press highlighted these cases and suggested that rationing of care may also be involved [6]. Concern was expressed about a lack of openness, lack of proper consultation with patients and relatives and decisions being made by junior doctors and documented in medical code [5, 6]. A British Medical Journal editorial, written by a prominent and respected academic geriatrician, supported the view that ageism was common in DNAR decision-making [7]. The Government issued a Health Service Circular condemning ageism and calling for more transparency in decisions and more involvement of patients and relatives [3]. This also reminded Chief Executives that NHS Trusts should have an agreed resuscitation policy in place that was known to staff but also accessible to patients, families and carers. This policy is required to be the subject of audit and to be reported as part of Clinical Governance on an annual basis.

It was against this background that the guidelines were published.

The new guidelines

Given the background, it is not surprising that the guidelines advocate a much more open and transparent decision-making process. Ambiguities, which seemed to have been present in previous versions, have largely gone, although a few are still present.

Competent patients

The guidelines clearly state that all DNAR orders should be discussed with competent patients, unless they indicate they do not want to do this.

This is one of the major changes in the guidance. Previously it has been suggested that if a doctor felt that a DNAR order was appropriate on the grounds that CPR was highly unlikely to succeed, then discussion with the patient was not necessary since there was no obligation to offer, or even discuss, useless interventions [8].

If a competent fully informed patient requests a DNAR order then the request should be respected, and the patient should be asked permission for health professionals to share this with those close to them. A competent patient may not wish information to be shared with those close to him and this must be respected.

If a competent patient's relatives disagree with the patient's decision then we would suggest that they are advised to discuss it with the patient, although doctors would be sensible to facilitate and document such discussions. If the relatives question the patient's competence to agree to a DNAR order, the situation becomes more complex. Doctors should be prepared to document and later defend their reasons for assuming competence and should discuss them with the relatives, with the permission of the patient. In an unstable clinical situation, if there is time, it may be useful to seek a second opinion from a senior clinical colleague. It is suggested in the guidance that legal advice may be necessary if issues cannot be resolved. It is not clear what form this should take and we suggest that consultants should ask for clarification of their possible options with their Trust management when local guidelines are being constructed. If a clear DNAR decision is made while a patient is competent then this must be respected, even if/when they later become incompetent, as long as the original decision fulfilled the tests for an advance directive. In other words, if the patient is clearly competent and fully informed about the consequences of the decision at the time of the request for a DNAR order, and circumstances later arise which are as had been envisaged in advance, then there should not be CPR attempts [9].

The guidelines state that if a competent patient does not want a DNAR order then one cannot be written.

This is obviously a difficult and sensitive issue and represents a change from previous recommendations. The guidelines now clearly allow competent patients the right to refuse to have a DNAR order documented in their case notes in advance, although we do not understand the theoretical basis for this recommendation. This does not mean that they must have CPR should the need arise, since the guidelines also recognize that doctors cannot be forced to provide treatment which they think is not clinically indicated.

Hence it is also stated that ‘(I) a doctor cannot be required to give treatment contrary to his/her clinical judgement and (II) it is unlikely to be considered reasonable to attempt to resuscitate a patient who is in the terminal phase of an illness or for whom the burdens of treatment clearly outweigh the benefits.’

It seems to us therefore that there is a built in ambiguity in the guidance which means that it is possible for a competent patient to refuse to let a decision be made in advance, forcing staff to make one in the heat of the moment when a cardiac arrest occurs. Clearly, if the situation deteriorates to the extent that cardiac arrest does occur, then the patient will have
become incompetent, but, unless circumstances are very
different from that envisaged when DNAR was
discussed, it is likely that the previous views would still
be valid. We think that it would clearly be sensible for
doctors to try and avoid such situations arising by
detailed discussion of reasons for a possible DNAR
order, a description of the processes and a realistic view
of possible outcomes. Patients (and professionals) often
overestimate the potential for survival after CPR [10, 11],
and we know that this influences requests for it [12].
Discussions with patients in these circumstances should
be clearly documented. If agreement for a DNAR order,
is not reached then the doctor should document what
should happen in the event of deterioration. However,
we believe that a practical effect of the guidance could be
that staff are effectively forced into performing
inappropriate CPR. The guidance seems to recognise
that this is a possibility when it states:

‘Doctors cannot be required to give treatment
contrary to their clinical judgement, but should,
whenever possible, respect patients’ wishes to
receive treatment which carries only a very small
chance of success or benefit.’

Incompetent patients

Incompetent patients’ relatives have traditionally seen
themselves as having a natural right to be involved in
decisions, and have reported feeling excluded [1]. Until
recently in England, Wales and Northern Ireland
they had no such right. (In Scotland it is possible for
patients legally to nominate a proxy decision maker). If
patients lacked capacity to decide for themselves
then their doctors were responsible for deciding ‘in
their best interest’. There was no obligation to involve
relatives, although it was regarded as a matter of good
practice [8].

Article 8 of the Human Rights Act recognises the
right to private and family life, and BMA guidance on
the Act suggests that excluding the relatives of an incompe-
tent patient from decisions may breach article 8.
However, it recognises that a balance needs to be struck
between the professional duty to maintain confidentiality
on one hand and the legal obligation to respect the right
to family life on the other, and that ‘if a patient expresses,
when competent, a specific wish that his condition
should not be discussed with relatives or friends then this
should be respected’.

The guidance on resuscitation decisions now states:

‘Unless to do so would be contrary to the
patient’s interests, people close to the patient
should be kept informed about the patient’s health
and be involved in decision making in order to
reflect the patient’s views and preferences.’

Later it says: ‘Where an incompetent patient’s
views on involving family and friends are not
known, doctors may disclose confidential informa-
tion to people close to the patient where this is
necessary to discuss the patient’s care and not
contrary to the patient's interests.’

It goes on: ‘Even where their views have no
legal status in terms of actual decision making, it is
good practice to involve people close to patients in
decisions.’

We believe this means that those close to incompe-
tent patients should usually be involved in discussion
about DNAR decisions, unless it is clear that the patient
would not have wanted this (it is recognised that a
considerable number may not) [13], or it is obviously
against the patient’s best interest. There seems to be
a distinction made in the guidance between seeking
information from family and friends about the patient
and disclosing clinical details to them; while they may
need to be ‘involved’ in decisions it seems that they
should not always regard this as a right to have access to
confidential information.

In England, Wales and Northern Ireland friends
and relatives are not being asked to decide on behalf of
the patient (this still remains the responsibility of the
consultant, in the patient’s ‘best interest’), nor are they
being asked what they would want for themselves in the
circumstances. Rather they are asked for information as
to the patient’s values and beliefs so that a decision can
be made which is in keeping with the patient’s wishes. In
Scotland, nominated proxy decision makers must also be
seen to be acting ‘in the best interest’ of the patient or
they may be open to legal challenge.

If the wishes of those close to the patient cannot
be complied with, then we would suggest that doctors
document their reasons for this and be prepared to
demonstrate that the decision is in the best interest of
the patient.

The guidelines use the term ‘those close to the
patient’ to indicate that specific relatives are not neces-
sarily identified, and recognising that others who are
not relatives (friends, partners etc) may have a closer
association with the patient than some relatives.

The families of incompetent patients may object
to proposals for DNAR orders insisting ‘everything
must be done’, although often there seems to be a
misunderstanding about what treatment is likely to
work. In these circumstances decision-making still rests
with medical staff, and families are being asked to
articulate what the patient's wishes would have been.
In theory families cannot therefore effectively veto DNAR
decisions for incompetent relatives in the way that
competent patients can do for themselves. The difficulty,
as we see it, arises when those close to an incompetent
patient state that the patient's previously expressed view
was that they would object to a DNAR order. We suggest
that the decision is only made once there are clear
facts about when the patient previously expressed that
view, and in what circumstances the patient wanted that
view to be upheld. Other members of the team,
including the patient’s General Practitioner may be able
to give valuable information. Again, second opinions or
legal review may be helpful. In Scotland, the presence of a proxy decision maker may help clarify the situation.

Disputes amongst family members are not uncommon. Doctors need to make a judgement, if possible, about which family member is most clearly reflecting the patient’s view. If it is not possible to do this then we suggest that they should carefully take into account the differing views, then reach a decision based on what they believe to be in the patient’s best interest.

‘Futility’ as a rationale for decisions

The guidelines reject the use of the term ‘futility’ in considering DNAR decisions, recognising the difficulty in defining the term [1]. Perhaps they also recognised the uncertainty likely to be inherent in making predictions of outcome based on the term futile and that some doctors may have found it useful in the past to avoid discussing CPR by rationalising that it would be futile [14].

Prediction of CPR outcome is difficult because it depends on so many factors; the previous clinical condition of the patient, the illness precipitating arrest, the mechanism of the arrest, the delay to and efficiency of CPR may all have a bearing. Morbidity Scores were developed to try and quantify the extent of pre-morbid illness that would make CPR futile, but it seems to us unlikely that they will be sensitive enough to guide decisions in individual patients with any degree of certainty [15–18].

The guidelines do not rely on the traditional outcome measure of CPR, survival to hospital discharge. This has been used in the past because those who survive to discharge have been thought to have a good prospect for long-term survival. The guidance suggests that doctors first consider prospects for restoration of pulse and respiration and then whether this would be of benefit to the patient. In many situations the burdens of prolongation of life outweigh the benefits but the guidance recognises that ‘where there is a chance of an outcome which the patient considers acceptable, many will consider the risk of even significant disadvantage a burden worth taking’. Many patients who initially respond to CPR die before hospital discharge, but there seems to be a recognition in the guidelines that, for some patients, even short-term survival in a debilitated state may have some value.

Decisions for all, or focusing on those most at risk?

Many geriatricians will have developed policies whereby all patients have decisions about CPR considered and documented on hospital admission [19]. Nursing and junior medical staff might feel more comfortable with this approach, perhaps on the basis that most patients in acute geriatric units would not be candidates for CPR in any event [14]. Given the possible complexity of the new decision making process and the likely increase in the time needed to make decisions we think it is unlikely that such an approach will be practical in future. It is still only a minority of patients in geriatric units who require CPR or who approach the stage where it might be considered; most are discharged alive [20]. Some die in hospital and some become very seriously ill but recover, and it is these patients for whom DNAR decisions should be considered. It may be argued that it is difficult to predict which patients might require CPR although the authors of a recent study of patients admitted to Intensive Care Units claim that clinical deterioration could have been predicted in many of them [21]. A combination of the widespread dissemination of general information about CPR and DNAR (an information leaflet is available on the BMA website [22]), and focusing decisions on those at highest risk seems to be the most practical way forward. This approach is favoured by the new guidance. This approach will mean that not every patient who has a cardiac arrest will have had a DNAR order considered. In such situations CPR should be attempted in keeping with local guidelines.

Who should make decisions?

Most geriatricians will welcome a partnership approach, led by the consultant but involving the multidisciplinary team, the patient and the family, although many will see practical difficulties with this. Ultimate responsibility, however, for making and communicating decisions, and ensuring that local policy is followed, still rests with the consultant, which may lead to some difficulty with other team members in the event of disputes.

The seniority of doctor who should be involved in decisions is not made explicit but the document refers to ‘senior, experienced members of the medical team with appropriate training in communication skills supported by similarly trained senior nurses’. Local policies should specify who this could be, but it seems likely that consultants or specialist registrars or those with similar experience will make decisions. Given that adverse publicity has surrounded decisions made in the past by senior house officers (SHOs) [5], local policies may not favour doctors at this level or below making decisions. Recognition is given to the importance of possible discussion with the patient’s General Practitioner.

Disagreement may also arise amongst clinicians. Junior doctors and nurses may be understandably unhappy if consultants feel that they cannot make DNAR orders on seriously ill patients. Decisions may be delayed if consultants have questions relating to competence or uncertainties about the clinical situation or perhaps if family members are not immediately available for discussion. Nurses and junior doctors are then asked to work in a more uncertain environment.

The resuscitation policy of a Trust should be familiar to all clinical staff. There may however arise situations where clinical staff are not familiar with the new
guidance. This may lead to disputes in the immediate post arrest situation.

In the event of disagreement, patients should remain for full active treatment while the dispute is resolved. Consultants (or the senior doctor involved) should clearly and carefully document the decision-making process. They should be prepared to consider second clinical opinions early and also the role of other members of the team in resolving disputes. They should be prepared to keep their organisation’s legal advisors informed of developments and be aware that legal advice may ultimately be necessary. It is probably more likely that consultants will be kept informed and involved in such decisions out of hours than has previously occurred.

What now? Practical advice

Geriatricians need to be aware of the guidance and how it might affect their practice. There seems little to be gained by complaining that the proposals are based on flawed logic or do not take account of practical difficulties. They should be heedful of the sensitivity surrounding this issue, both among the public and other clinical staff. They should caution junior doctors about making hasty decisions or of being pressurised into involvement in decisions inappropriately. They should be aware that discussion about CPR with patients and relatives by staff who are well intentioned, but inexperienced, may lead to difficulties [19]. They should ensure that decisions are only made by experienced clinicians who carefully document the process in clear, easily understood terms. They should audit their decisions or make them available to others to audit.

In the longer term they are advised to familiarise themselves with the DNAR policy of their organisation and ask for clarification of areas of doubt. In particular they should ensure that they know the process for accessing legal advice, especially outside normal working hours, and the process for dealing with disputes. They should ensure that the limits of consultant responsibility are clearly defined.

They might also consider asking their Chief Executive or Medical Director, in writing, for training in communication skills for this specific area if this has not been offered, and to provide such training to nursing and junior medical staff. The guidance specifies that appropriate training in communication skills should be given to the senior doctors who make these decisions; some may feel this unnecessary, although the reports of the Health Service Commissioner frequently highlight communication between doctors and patients as a problem area; in some instances this has specifically been around CPR [23].

If they have reservations about areas of the policy or implications of it then they should also highlight these. For example, they may feel that decisions will be more difficult in a particular community setting because of staffing issues or there will be a significant impact on ITU bed use because of more CPR attempts. Many may feel that the time that they are required to spend discussing CPR with patients and families will mean that they are less able to carry out other duties. They may feel that their Trust should provide trained staff, perhaps in a nurse specialist or similar role, who could give advice and support for staff and specific counselling in difficult cases.

Summary

New guidelines for DNAR decision-making are very different, and may mean that British geriatricians face a difficult change in their clinical practice over the next few years. Coming at a time of a changing relationship between doctors and the public we should be aware that these decisions have a sensitivity that perhaps had not been recognised before. We should be prepared to work within the guidelines in keeping with the spirit of openness and transparency but not be afraid to highlight the limits of consultant responsibility, or the implications that this way of working may have for other care.

Key points

The new guidelines take into account most of the articles of the European Convention on Human Rights which were incorporated into the UK law in 2000. In the decision making process guidelines recommend:

- Involvement of senior experienced doctors, who have had training in communication skills, and other professionals, particularly well trained senior nurses.
- Recognising the right of the competent individual to be involved in decisions and to refuse DNAR decisions.
- Rejection of futility as a rationale and instead consideration of the prospect for restoration of pulse and respiration initially and then to consider if this will benefit the patient.
- More sensitivity to the place of relatives and friends in the process, although their role in decision-making remains the same.

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References

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