‘Do not resuscitate’ orders: the need for a policy

ABSTRACT—The use of ‘do not resuscitate’ (DNR) orders is widespread in UK hospitals, but until recently there has been no formal policy for this practice. The decision not to resuscitate should be made on ethical and medical grounds. The ethical implications for such decisions are explored. A review of current practice reveals considerable variation in the way in which DNR orders are made. Patients are rarely involved in the decision. There have been failures of communication between doctors and nurses, and between consultants and their juniors. These issues have now come to public and professional attention. There is a need for coherent national and local resuscitation policies that should take into account the medical, ethical and practical aspects of DNR decision making.

Since the 1960s, cardiopulmonary resuscitation (CPR) has become an everyday practice in UK hospitals. Most resuscitation attempts are unsuccessful, but some patients do survive, and widespread provision of CPR is the norm. In the US, CPR is attempted on 30–50% of patients who die in hospital; in the UK the figure is probably lower—about 20% [1]. As most deaths now occur in hospital, the potential number of candidates for CPR is clearly enormous. But some patients are deliberately excluded from CPR: they are the ones for whom DNR orders are made. Although DNR orders are widely used in UK hospitals, there has been no systematic policy for this practice until recently. This is now changing with the realisation that DNR policy is of public as well as professional interest. It is as integral to CPR provision as equipment and training.

Ethical aspects

Deliberately withholding potentially life extending treatment is an act with moral implications. The moral aims of medical intervention have been defined according to the following principles [2,3]:

- the principle of beneficence—to do net good;
- the principle of non-maleficence—to do no harm;
- the principle of respect for the patient’s autonomy;
- the principle of justice.

The principles of beneficence and non-maleficence can be considered together. CPR should only be used if it will produce net benefit for the patient. CPR is not harmless—it has been described as a violent, damaging, painful, alarming and undignified intervention [4]. In many cases the assessment of benefit over harm requires a value to be put on the patient’s quality of life—and the patient’s own view is central to this judgement.

Respect for the patient’s autonomy implies informed consent for any treatment decision, including CPR. There are two exceptions: if CPR is deemed medically futile, or if the patient does not want to be involved in the decision. Whilst some patients do not want to be involved, in general, patients would like more communication with their doctors [5]. Anecdotal evidence suggests that doctors simply do not like asking patients about DNR decisions, often on the grounds that patients would be upset by such a discussion. Yet research among elderly patients in hospital has shown that the majority would welcome the opportunity to discuss resuscitation choices [6]. Research also shows that doctors are not very good at guessing their patients’ resuscitation preferences [7,8].

If CPR is deemed to be futile, ie ineffective or of no medical benefit, then doctors do not have to offer it [9]. Only 6–15% of CPR cases leave hospital alive [10, 11]. In fact, if a patient is thought unlikely to survive an attempt at CPR, even to offer it may go against patient autonomy by presenting illusory choices. The definition of futility is not straightforward—for some patients even a few extra hours of life may appear desirable. Value judgements are involved in defining futility. Judgements of medical benefits depend on good data on the outcomes of medical interventions, and estimations of outcome can never be 100% accurate. Whilst some ethicists hold that patients should always be offered CPR, a less extreme view is that it is within the legitimate professional role of doctors to define the absence of medical benefit, but not to make quality of life decisions without involving the patient [12].

The ethics of DNR orders for mentally incompetent patients are particularly complex. If a patient is not competent, a surrogate’s view may be sought. The principle of respect for autonomy still applies to the patient, so it is not the surrogate’s own view that is sought but the surrogate’s opinion of what the patient would have wanted. This is the principle of substituted judgement. The patient may have designated a surrogate, but often it is assumed that the next of kin will
fill this role. In any case, the doctor’s legal duty is to pursue the best interest of the patient.

According to the principle of justice, all patients have an equal right to be treated fairly, and there must be a fair distribution of scarce medical resources. For instance, resuscitating a patient in a persistent vegetative state would go against the principle of justice [4], as well as being of doubtful benefit.

The basis for DNR orders falls into three categories [9].

1. CPR is of no medical benefit.
2. The current quality of life is poor.
3. The quality of life after CPR is likely to be poor.

This classification takes into account the issues of futility, patient consent, and quality of life judgements. For DNR decisions in the first category patients do not need to be consulted, but in the other two they should be.

Current practice

Systematic information about the operation of DNR orders in the UK is not available, but there is a great deal of anecdotal information from doctors and nurses working in hospitals at all levels, and a few descriptive studies of DNR procedure.

CPR equipment and personnel are a standard feature of hospitals with acute beds. In other types of hospitals such as long stay geriatric homes or hospices the situation is more variable; they often have only minimal equipment or none at all. Studies at three different London teaching hospitals found that about 20% of patients who died had received CPR [13,14] and that 30% of acute admissions had DNR orders [15,16]. A follow up study of crash calls at 12 general hospitals found an average of 20 CPR attempts per hospital per month [11].

The majority of calls are initiated by a nurse who has either witnessed the cardiac arrest or found the collapsed patient. The patient’s resuscitation status may already have been decided but if this is not the case, a decision to initiate resuscitation is made in the heat of the moment by a relatively junior member of staff. In practice three different types of policy tend to operate, whether formally acknowledged or not:

1. An ‘opt-out’ policy where all patients are deemed for CPR unless a specific decision has been taken to the contrary.
2. An ‘opt-in’ policy in which all patients have DNR status unless designated for CPR.
3. Every patient has a specific CPR status decision made—either for CPR or DNR.

In general, opt-in and opt-out systems seem to operate informally in that they are descriptions of how staff behave rather than explicitly stated policies. At least two studies have found evidence that junior staff operate informal systems in which some patients are excluded from CPR in the absence of a written DNR order [15,17]. In these cases, the decision not to resuscitate may be clinically sound, but raises legal problems.

There is no uniform way of recording a DNR decision: a variety of codes and jargon phrases is used, or the decision may deliberately not be recorded in writing at all. In some cases, at least, it seems as if the system is designed to prevent patients or their families from discovering the existence of a DNR order. Even in a single hospital, written DNR orders may be recorded only in the medical notes, or only in the nursing notes, or in both [16,17]. There is often no system for regular review of a DNR decision.

Anecdotal evidence suggests that patient or family involvement in DNR orders is not common practice. In one study only 6% of mentally competent patients with DNR orders had taken part in the decision [18].

The spectre of the inappropriate crash call looms large in hospital folklore. A junior nurse finds a patient collapsed and pulseless and a crash call is put out. The crash team leave their other tasks or possibly their beds and race across the hospital. After 20 minutes of their full efforts a pulse is re-established and preparations are made to transfer the patient to CCU. Only then does it transpire that the patient is a nonagenarian, severely demented, and has a metastatic cancer. No-one’s purpose has been served. The patient’s last hours have been subject to a useless and traumatic intervention. The relatives are distressed. The doctors are disillusioned and cynical. The junior nurse is disciplined for her inappropriate actions.

There is no published evidence to suggest how many crash calls are inappropriate, but the above scenario is commonly recounted. The opposite scenario, where a patient is inappropriately not resuscitated, is not often described. Either case results from the absence of systematic written documentation of patients’ CPR status by doctors, and the failure of communication between doctors, patients, and nurses. Nurses especially are put in a difficult situation as they are the most likely to have to make the decision to call the crash team. While some consultants do apply clear and consistent DNR policies this is probably still the exception rather than the rule.

The US model

The exclusion of patients from CPR has been widely discussed in the US. DNR policies are now in use in over half of US hospitals [19]. DNR orders typically require patient or family consent and a written record.

In 1987 New York became the first state to enact legislation for withholding CPR. According to this, every patient who has not consented to a DNR order is presumed to consent to CPR. If the patient is mentally competent the doctor must obtain the patient’s consent in the presence of two witnesses before making a DNR order. If the patient is mentally incompetent and
two doctors state in writing that the patient is terminally ill, or irreversibly comatose, or that CPR would be medically futile, then a surrogate may consent to a DNR order.

This law has been considerably criticised on the grounds that doctors would be legally bound to attempt CPR on patients in whom they believe it to be useless or harmful. In fact, a retrospective analysis of patients who died in a teaching hospital three months before and three months after the law took effect found no significant increase in the number of CPR attempts [20]. The frequency of written DNR orders in patients who died without CPR increased dramatically from 22% to 93%, but a similar improvement in recording of DNR decisions has also been observed simply with the introduction of a formal hospital DNR policy [21].

The US approach to DNR orders has been criticised for ignoring the medical indications for or against CPR in favour of ethical and legal considerations [22].

Recent events

Many institutions and professional bodies are now producing DNR policies. They can be divided into local hospital based policies, and broad guidelines produced by national bodies. Several recent events have contributed to this development.

In 1990 a complaint was made to the Health Service Commissioner. It concerned a patient for whom a DNR order had been made without consulting the patient or her relatives. There had also been a failure in communication between the consultant in charge and the junior members of the team [23]. The case was reported in the national press and discussed in parliament [24, 25]. MPs commented on the need for a written policy and for patient consultation. As a result, in December 1991 the Chief Medical Officer (CMO) wrote to all consultants in England stating that consultants have a responsibility to ensure that their DNR policy is understood by all staff who may be involved, particularly junior medical staff [26].

Patient choice and patients’ rights are considered increasingly important in health care. The making of ‘life or death’ decisions by doctors without consulting patients or relatives is against this trend. Such choices are no longer seen as purely medical.

In April 1992 the Ethics and Nursing Committee of the Royal College of Nursing published a report on resuscitation decisions [27]. The document was a direct response to the increasing anxieties of RCN members about inappropriate responsibility placed on junior nurses to make resuscitation decisions. The report provides guidelines for nurses in the absence of a formal DNR hospital policy.

Other recently produced guidelines include those of the Royal College of Physicians [28], the British Geriatrics Society [29] and the Royal College of Radiologists [30]. The BMA is also producing guidelines jointly with the UK Resuscitation Council. The different documents inevitably reflect a variety of concerns and carry different emphases. Some concentrate on ethical issues whilst others are mainly concerned with the ‘mechanics’ of resuscitation policies.

Many hospitals have taken the CMO’s letter as a directive to produce DNR policies. The process varies from hospital to hospital. It is usually consultant led, with variable input from other professionals. In many cases there is input from the local ethics committee, which may include lay members. Again the content of these policies varies depending on particular local concerns.

Conclusion

A formal resuscitation policy is a way of ensuring the quality of resuscitation decisions. The medical and nursing professions have begun to respond to this need. At both national and local levels policies are being formulated and many different organisations are independently and simultaneously producing documents. This may lead to confusion. The respective functions of local policies and national guidelines may also need clarification.

A single set of national guidelines from all the interested bodies could avoid confusion and promote consensus. National guidelines are a good way to establish fundamental issues such as the ethics of non-resuscitation and medical effectiveness and to decide on principles such as patient autonomy.

Hospital policies are needed to determine aspects such as level of seniority, frequency of review, method of recording and the detailed requirements for patient consultation. Consultants and nurses should devise local policy to meet individual concerns and to maximise implementation.

The issue of patient consultation remains a problem. From an ethical point of view it is of central importance. However, because many doctors are reluctant to discuss DNR orders with their patients, a policy that makes patient consent a universal requirement of DNR orders is likely to fail. It would be naïve to expect that a set of ethical guidelines could alter entrenched attitudes to communication with patients. One approach would be for national guidelines strongly to recommend patient consultation, while leaving the exact details to local policies.

There is no place for the deliberate non-recording or obfuscation of DNR decisions. This militates against good communication between all concerned. All DNR policies should require written orders.

Apart from the RCN report, DNR policy and guidelines have so far been primarily formulated by doctors. However, DNR policy can no longer be seen as purely the business of doctors or other health professionals. The moral aspect of these decisions places them in the public arena. Policies and guidelines will carry more
conviction if they include lay views and those of ethicists, as well as of doctors and nurses.

Appropriate DNR decisions depend on good outcomes data. Whilst considerable information is available, systematic outcomes data on prognostic subgroups, including the effect of age, are needed. The data already available could be used to develop DNR decision protocols. This would improve the scientific basis on which these decisions are made. The collection of outcomes data according to prognostic subgroup is already underway on a national basis [11] and it may be appropriate to expand it. Audit of hospital DNR policies can be used to evaluate the quality of care and the effectiveness of the policies. As well as the outcome of CPR attempts, other topics suitable for audit could include DNR decision recording, level of patient consultation, and appropriateness of DNR decision making.

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