

Perspectives on CPR: resuscitation or resurrection?

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ABSTRACT – The use of cardiopulmonary resuscitation (CPR) is controversial. Recently allegations of age discrimination have been made. Revised guidance from the British Medical Association, Royal College of Nursing and the Resuscitation Council (UK) provides valuable help, including implications of the Human Rights Act 1998 and the Adults with Incapacity (Scotland) Act 2000. Patients do not have rights to useless treatments and CPR should not be used if there is no reasonable prospect of success. Current evidence suggests that legislation would not be helpful.

But whether the gate of my prison be opened with an oiled key (by a gentle and preparing sickness) or the gate be burnt down by a raging and frantic fever; a gate into heaven I shall have.¹

With such enormous production individual deaths are not well looked after, but that is not the point either. It is quantity they are after. Who cares nowadays about a well arranged death? ... The desire to have a death of one's own gets rarer and rarer. In a little while it will be as rare as the desire to have a life of one's own.²

Cardiopulmonary resuscitation (CPR) is attempted on too many patients. At its best, CPR is the gift of life: chest compression, ventilation, intravenous medication and defibrillation followed by years of productive and fulfilled being. At its worst³⁻⁵, it offers a scenario of vomit, blood and urine, then a confused, brain-damaged twilight, breathlessness from a failing ventricle, pain from rib fractures, until expiring in thrall to the full panoply of the intensive care unit or forgotten in the long darkness of the persistent vegetative state. No humane doctor would consider this a good death, nor would any poet, priest, painter, musician or novelist use images of CPR to represent the Good Death. Rather, the images are more likely to be those of the factory: death in the industrial age. CPR is a lottery – the odds are good for some and the winnings are life itself. For most, the odds are poor and the outcome for some worse than the death that CPR is designed to avoid. The key to better outcome is better selection, but we often do not know how to select, even if we do know when to stop⁶. An effective treatment for the select few becomes an industrial rite of passage for the many. Our problem is how does the competent patient – or the doctor trying to fathom the incompetent

patient's best interests – determine whether to buy the lottery ticket?

People do not always mean what they say; they do not always say what they want; and they do not always want what they say they want. That much is, if not exactly clear, at least uncontroversial. What is controversial is, recognising this, how to proceed.⁷

In few areas of medicine is that truer than in the debates around CPR. Surveys abound, but the practical guidance given to clinicians is limited. In one study, 18% thought CPR should be given to patients with 'terminal cancer'⁸; in another, six patients with carcinomatosis wanted CPR⁹. Hill *et al*¹⁰ reported that one-third of doctors would resuscitate patients with incurable malignancy, yet concordance between doctors' and patients' views are little better than chance. In a study of 1,438 seriously ill patients, health values were found to vary enormously, changed over time, related to few other preferences or health status measures and were higher than surrogates thought¹¹. Despite the belief that they knew patients well, physicians were no better than interns in assessing the preferences for CPR of 230 seriously ill adults and both had only a fair understanding of those preferences or quality of life¹².

It was against that background that last April the charity Age Concern mounted a campaign over the alleged practice of designating elderly patients as 'not for resuscitation'. The index case was a 67-year-old woman, Jill Baker, suffering from cancer. She was reported as having 'spotted a "do not resuscitate" (DNR) order on her medical notes' after she was admitted for treatment at St Mary's Hospital, Portsmouth¹³. The reported details of Mrs Baker's case may suggest that the DNR decision had more to do with her incurable malignancy and sepsis than her age, but the implications of this possibility – equally significant and controversial – went unexplored. Age Concern went on to claim that it knew of more than 100 similar cases that it promised to bring to the attention of Alan Milburn, the Health Minister. This was evidence that UK doctors were 'increasingly' deciding not to resuscitate seriously ill elderly patients¹⁴. Further allegations followed. Thus, junior doctors were allegedly being 'coerced and cajoled' to refuse resuscitation and 'pressurised by nurses' to enter DNR orders in case notes¹⁵, while reverence for

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clinical freedom was simply allowing doctors to exercise their prejudices¹⁶. Age Concern's director general suggested that the elderly population were 'terrified' by reports of DNR orders being written in their notes¹⁷.

Controversy over selection for CPR was confused by wider assertions about 'ageism' in the health service: that is, the belief that age has been wrongly considered a morally relevant factor in the allocation of resources in healthcare. In a *British Medical Journal* editorial it was claimed¹⁶ that 'medical students still rejoice in their stereotypes of geriatric crumble and GOMER (get out of my emergency room) patients'. This defamatory and prejudiced statement was made with no evidence (I cannot find any student who knows what the letters GOMER even stand for) but was predictably widely reported in the national press. Inflammatory comment of this sort led to the call for legislation 'to put a stop to this practice'. Drawn in to comment, the Health Minister stated that 'A blanket "do not resuscitate" policy based on a specific patient group, such as elderly patients, is unacceptable¹⁸. No hospital with a specific age-related DNR policy was reported, however.

Many doctors will groan at yet more bad press for the profession, while others will have a sense of *déjà vu*, for the recent events resemble those of ten years ago. In his annual report in 1991, the Parliamentary Commissioner for Health ('ombudsman') drew attention to the case of a woman of 88 admitted to hospital with pneumonia and designated not for resuscitation. His investigation revealed that neither the admitting doctor nor others thought that relatives would normally be involved in such decisions. As now, this incident led to national press coverage¹⁹ and an editorial in the *College journal*²⁰. The government's Chief Medical Officer subsequently advised that all hospitals should have policies in place and wrote to all consultants²¹. The British Medical Association (BMA) and the Royal College of Nursing (RCN) responded by the joint publication of guidelines²². Although less detailed than those from the American Medical Association²³, they were widely circulated and formed the basis for DNR policies in many hospitals. The recent furore suggests that they have not been studied or applied by many physicians. Their revision and re-publication in response to the current concerns is welcome²⁴.

The new guidance is longer and clearer. Its admirable starting point is a statement of the goal of medicine. It covers both children and adults, the competent and the incapacitated, and the need for discussion and the involvement of others close to the patient (albeit without comment on the witnessing of CPR by relatives)²⁵. It emphasises the low success rates in most situations. The legal framework is covered both with respect to the Human Rights Act 1998 and the Adults with Incapacity (Scotland) Act 2000. Its three charts of 'issues for consideration' provide a concise summary of the essentials. It is a document that should be studied by every clinician.

Better communication, more public education and greater transparency are of course required. This includes a need for clarity about the word 'discussion'. A recent *British Medical Journal* editorial¹⁶ was subtitled 'should not be withheld ...without discussion'. There may also be a growing feeling that

CPR should always be attempted unless discussion has taken place, if not with the patient then at least with the relatives. This is not a morally defensible position. Patients do not have a right to useless treatments nor doctors a duty to provide them on demand. Autonomy is not enhanced or respected where one choice offers no reasonable prospect of a particular outcome. As Tomlinson and Brody²⁶ observe, removing power from the physician by complex DNR procedures does not necessarily enhance the autonomy of the patient. Given that CPR is an increasing part of public expectation, it may be necessary to explain its irrelevance to patients and relatives when its application is futile. In the busy acute medical admissions unit, time may not always permit this. But the word 'discussion' is often taken to mean rather more: a decision to be made. The 1993 BMA/RCN guidance²² rightly stated that:

when the basis for a DNR order is the absence of any likely medical benefit, discussion with the patient, or others close to the patient, should aim at securing an understanding and acceptance of the clinical decision that has been reached. (my emphasis)

It often is not necessary to discuss a DNR *decision* and, moreover, often impractical to do so. It is, one should hardly need to add, permissible to discuss with relatives only with the permission of the competent patient, and the eventual decision must be based on the best interests test, applied by the doctor. Relatives have no power of proxy consent in England and Wales.

The new guidance now avoids the term DNR in favour of 'do not attempt resuscitation' (DNAR)²⁴. This puts the emphasis in the right place. CPR is not a treatment for death or for the dying, a twenty-first century rite of passage²⁷ or an attempt at resurrection. Its use in these circumstances is not simply inappropriate but immoral: the infliction of an undignified assault at the end of life. Much the same could be said, incidentally, when a patient is found in a side ward who has obviously been dead for some time, even if designated for CPR. The problem here has been the reluctance of many doctors to make the diagnosis of dying, to move the dialogue with patient or family into a different mode²⁸. American experience suggests that many doctors make resuscitation decisions because of fear of litigation or criticism. A majority admits to attempting resuscitation despite expectations that such efforts would be futile²⁹. This is not ethical practice, for it uses patients not as ends in themselves but merely as means to the ends of others. CPR is not a harmless technological placebo, but can result in harm to patients, families, doctors and society³⁰.

The notion of futility has produced an enormous literature³¹⁻³³, both as to what it means and to who determines it. It is not simply a claim of facts over values. Suffice it to say here that professional integrity implies that doctors cannot be expected to carry out a treatment they know to be useless in achieving the desired end.

CPR is usually unsuccessful and if more widely applied it will be proportionately even more unsuccessful. It was originally introduced as a treatment for sudden unexpected death – myocardial infarction, overdose, drowning and so on³⁰. Its success depends on the environment in which it is carried out.

In the coronary care unit, it is little more than a routine therapy for a rhythm disorder and success rates may exceed 50%. But if undertaken in hospital wards the number of patients surviving to discharge is around 10–15%^{34,35}. Its success is grossly overrated by the lay public, to a lesser degree by nurses and is even overrated by doctors^{36–39}.

Relatively early in the history of CPR there was a suggestion that it was being used too indiscriminately. Anecdotes of inappropriate use appeared in the journals^{3–5} and one *Lancet* editorial⁴⁰ was even entitled 'cardiac resuscitation in hospitals: more restraint needed'. It commented: 'we do not normally recommend treatments that have a 97% failure rate'. It is interesting to reflect that we do. For, as commented in this journal recently⁴¹, thrombolysis was accepted as a routine therapy in myocardial infarction on the basis of a trial that showed an absolute mortality benefit at around the 3% level. If this is an observation of how we do behave, most might be expected to think that we should at least offer CPR at this level of benefit. Data are often inadequate to guide us, judgement is indeed difficult, and some will weigh the odds differently. Our responsibility is to make individual judgements informed by accurate information according to pathology and situation, whether or not in discussion with patients. But perhaps we should not offer CPR if success is below the 1% level, especially if there is a possibility of permanent vegetative state, which many will consider worse than death, at a similar level of probability⁴².

In a survey at the Whittington Hospital, London, in 1990⁴³, it was suggested that perhaps 40% of patients should not be designated for resuscitation in general medical wards. In a subsequent study, the same author found that 30% of all elderly inpatients had morbidity scores which indicated that CPR would be likely to fail if attempted⁴⁴. About a third of all elderly medical inpatients had a mental test score of less than 7 out of 10 (indicating at least moderate confusion) or else were too ill to complete a score, so would be unable to participate in decisions. If relatives are not available, the doctor must make the initial decision in the best interests of the patient without consultation, and must not refrain from a DNAR order because competent discussion has not taken place.

In one study, over 50% of patients who survived CPR arrested on the day of admission, and the mean time from admission to arrest was 1.7 days⁴⁵. Resuscitation status should be ascertained at the time of admission and, like any other therapy, junior medical staff may take this decision pending later confirmation, or seek consultant advice if uncertain. Discussion about the decision is likely to be required with patients and families in a minority of cases. Such discussion is skilled and time consuming. It needs training and is a task for the experienced^{46,47}. A perfunctory question such as 'If your heart stops, do you want us to try to resuscitate you?' does not meet the information standards required for informed consent.

Legislation in New York State had no effect on the use of CPR, although it increased the number of DNR orders⁴⁸. This experience, in a society with a stronger tradition of legal regulation, suggests that legislation would not help in the UK.

Key Points

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New guidance on 'do not attempt resuscitation' has been published

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This followed allegations of inappropriate decisions

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Patients do not have rights to useless treatments

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Better communication and transparency may imply the explanation of the appropriateness of a DNAR order where there is no prospect of success

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Legislation is not likely to be helpful

Finally, the new guidance is surely right to advocate that leaflets should be available for patients and people close to them explaining about CPR, how decisions are made and their involvement in decisions. Advance decision-making is a difficult concept for some to grasp: a decision *now* is about how we believe a patient will be *then*. Transparency and openness are the key to trust, especially where there are no easy answers. There are local issues in CPR policies and a good case for ensuring that information leaflets have been approved by the trust's patient liaison committee or (in Wales) the community health council. Perhaps there is a role for the College in drawing up a basic template for an information leaflet. Physicians, after all, are the one specialty group that is always involved in hospital CPR.

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