Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

An audit into consultation in 'do not attempt resuscitation' decisions

Guidelines concerning 'do not attempt resuscitation' (DNAR) decisions have been clarified in recent years in the light of public anxiety and a decreasingly paternalistic approach to medical practice. The Department of Health and the General Medical Council refer to comprehensive guidelines published jointly by the British Medical Association, the Resuscitation Council and the Royal College of Nursing.[1]

Those paragraphs in the document concerning consultation are based on the following principles:

- A competent patient should be involved in the decision unless he or she does not want to enter into such a discussion.
- The subject, when discussed, should be explored sensitively and carefully.
- In the case of incapacity, doctors have authority to act in a patient's best interests, but unless such involvement would be detrimental to these interests, people close to the patient should be involved in the decision so that the patient's views and preferences can be explored.

To encourage adherence to these guidelines 'DNAR forms' have been introduced in many institutions. Tick boxes prompt the doctor to state why the decision is being made, if it has been discussed with the patient or someone close to the patient, and if not, why not. To assess how closely physicians in a district general hospital were following current guidelines, all the DNAR forms in the notes of medical patients were examined for completeness over a period of four days.

In total, 228 sets of notes were examined. Of these, 63 (28%) contained a DNAR form. The forms' sections concerning consultation, and the frequency with which they were completed, are presented in Table 1.

Discussion

'Not for resuscitation' decisions were discussed with either the patient or a representative in 17 out of 63 (27%) cases. Representatives were always close relatives. One patient had made an advance directive, and this was discussed with him when the DNAR order was made. Incapacity was the main reason for not involving patients, but in 40% of cases no reason was given at all. Of the 46 cases in which the team did not confer with the patient or a nominated representative, it was not discussed with anybody else 'close' to the patient in 20, or 43%.

This audit revealed that DNAR decisions are rarely discussed with patients, and with those close to the patient less than half the time. Many decisions are made without any recorded discussion. The disparity between recommended and observed practice is striking. Possible reasons for this are alluded to in comments observed on the forms. There are apparent difficulties in contacting and meeting relatives. '*She would understand*' reflects a paternalistic attitude, while '*Inappropriate*' conveys the confidence with which the physician has judged the situation. The high number of blanks raises questions about doctors' attitudes to such forms, and to the expectation that they explain their thought processes. Time pressure is another consideration. The published guidelines state that discussions should be undertaken by 'senior, experienced members of the medical team'. If such discussions, and their documentation, are assumed to take a minimum of 10 minutes, and are conducted for the most part by consultants, the 63 DNAR orders

Table 1. Statements concerning consultation on DNAR form to be completed by ward doctor, with total numbers of responses.

		of 63 DNAR forms		%
1. I [the ward doctor] have discussed this [decision] with ∞:				
The patient	☐	3		5*
Patient's nominated representative	☐	14		22¶
Consultant\Deputy	☐	38		62
GP	☐	0		0
Nothing recorded	☐	8	A	13 B
2. I have not discussed [this decision] with the patient because:		of 60 (A)		%
The patient is incapacitated	☐	30		50
Other [please specify rationale]	☐	6		10±
Nothing recorded	☐	24		40
3. I have not discussed this with those close to the patient because:		of 46 (B)		%
Patient has asked me not to	☐	0		0
I am unable to contact them	☐	13		28
Other reason, please state	☐	7§		15§
Nothing recorded	☐	30		65

∞ More than box can be ticked (eg consultant and representative)
* 1 advanced directive or 'Living Will'
¶ 1 spouse, 2 nieces, remainder sons and daughters
± 4 'inappropriate', 1 'she would understand', 1 ticked but no reason given
§ All 'Not on ward' (in 4 cases 2 boxes were ticked, *'I was unable…'* and *'Other reason - not on ward'*), hence total adds up to 50.

identified in this study represent over six hours spent with patients or their loved ones. If over a quarter of medical patients are assigned a DNAR order, as in this study, it may not be surprising to find that the ideal is not always achieved.

Expected deaths rarely result in complaints from relatives concerning the decision not to resuscitate, and such decisions are certainly appropriate in the most cases. The fact that appropriate DNAR decisions are being made outside the terms of published guidelines suggests that physicians remain confident in their ability to make such judgements, and do not feel obliged to record their adherence.

Reference

1 BMA, Resuscitation Council (UK), Royal College of Nursing. *Decisions relating to cardiopulmonary resuscitation: a joint statement from the BMA, Resuscitation Council (UK), and the Royal College of Nursing*. London: BMA, RC, RCN, 2001. www.bma.org.uk/ap.nsf/Content/cardioresus

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