DO NOT ATTEMPT RESUSCITATION (DNAR)

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In December 2001 Morecambe Bay Hospitals NHS Trust approved a new resuscitation policy. This offers guidelines in circumstances where it may not be appropriate to carry out cardiopulmonary resuscitation.

Clinical staff are regularly faced with this ethical dilemma. Nationally, criticism of decisions or the way in which they were made has been rife. Emotive headlines seemed to fill many of the tabloids. There is, however, little consistency in the criticism and it can vary from anger that a patient was not given the opportunity to discuss the issue or fury that the medical staff frightened them by raising it. It is therefore not surprising to learn that solicitors featured in putting the current policy together.

This article aims to examine some of the issues, to offer suggestions to improve the current situation both locally and nationally and to promote debate and awareness in what can often appear to be a no-win situation for medical and nursing staff.

It looks at medical circumstances where it would be considered inappropriate to begin cardio-pulmonary resuscitation (CPR), including when planning for an inevitable death and progressively irreversible conditions where resuscitation would probably be futile. In addition it respects the rights of the patient to refuse resuscitation.

It encourages consultation with patients and their relatives and emphasises that the responsibility remains that of the consultant. It also stipulates that the decision should be reviewed regularly, suggesting that this is done daily or at least at every registrar's or consultant's ward round and that a DNAR decision should be countersigned by a witness.

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COMMON PROBLEMS THAT CAN ARISE WITH DNAR DECISIONS

1 Public perceptions

To viewers of television programmes such as ER, Casualty and the many soap operas on offer it would appear that our own cardiac arrest teams are nothing short of incompetent. Time and again victims of cardiac arrest are successfully resuscitated and gratefully gaze up into the eyes of their saviours. It is not surprising that there is a public perception that resuscitation is a something of a medical miracle. In a recent training session at a local school 30 sixth formers were asked 'How often do you think resuscitation is successful in hospitals?' The unanimous response was 95% or more.

In 2001 an audit of cardiac arrests at the Royal Lancaster Infirmary and Furness General Hospital revealed a success rate (return of spontaneous circulation), of 15%. This reflects the national average of 10-20%⁽³⁾. This number may be improved with the deployment of more Automated External Defibrillators (AEDs) which empower more nurses, often the first responders at an arrest, to defibrillate. This has been encouraged in the NHS Plan⁽⁴⁾.

The figures, however, do not comply with the expectations of the public and although there may be improvement it is unlikely to reach 95%.

In 2000 Age Concern mounted a campaign about resuscitation not being attempted on elderly patients, the implication being that the decisions of DNAR were not necessarily based on the clinical condition of the patients but on their age. Further allegations that junior doctors were being pressurised by nurses to make DNAR orders

Demonstration of resuscitation

THE POLICY

All NHS trust executives are required to ensure that policies are in place⁽¹⁾. They must:

- respect patients' rights
- be understood by all relevant staff
- be accessible to those that may need them

The policy itself is in line with the joint statement made by the British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing⁽²⁾.

on elderly sick patients followed. Indeed it was suggested that doctors' clinical freedom allowed them to exercise their ageist prejudices. Although Alan Milburn, the Health Secretary, stated that there should be "no blanket 'do not resuscitate' policy based on specific patient groups, such as elderly patients" there was no report of any hospital that adopted such a practice⁽⁵⁾.

In addition some patients have concluded that DNAR is tantamount to passive euthanasia and means that all other treatments will be withdrawn. They may have a sense of abandonment by the medical and nursing staff, despite reassurances to the contrary.

Thus a clinician wishing to raise the issue of resuscitation with a patient enters an emotional minefield. Moreover, explanations and discussions of this nature take considerable time, especially where misconceptions and fears are deep-rooted. This time is often not available.

2 Cardiac arrest team morale

The issue of DNAR is rightly patient-focused but the issue of the team's morale is often left out of the equation.

Fictitious scenario:

At 5am an 87-year-old lady is admitted by a GP having fallen at home and become confused.

PMH: Diabetic (type 2), history of TIAs and IHD.

On admission to the medical ward she appears emaciated and semi-conscious.

The junior doctor does not feel confident to make a decision regarding DNAR and decides to wait until the consultant's ward round at 8.30am.

At 6.30am a nurse going round with some teas discovers this lady slumped in the bed and confirms cardiac arrest.

The cardiac arrest team respond to the call.

Basic life support commences although due to her frailty a number of ribs are fractured. The monitor shows asystole. Full resuscitation continues, including intubation, for about 15 minutes, after which the patient is declared dead.

The arrest team is bound legally and professionally to perform full resuscitation on a patient unless otherwise instructed by a consultant. However, Resuscitation Officers (ROs) and others may be approached by distressed or angry team members after the event. To perform resuscitation on an individual who is extremely unlikely to respond can have damaging effects on morale within the team. These arrests can be vividly recalled years

after the event. Guilt can be very real, and team members feel that they did not afford the patient a peaceful and dignified death.

RAISING AWARENESS

There have been two seminar/workshops on DNAR held in the trust so far and more will follow. The aim has been to allow open and frank discussion and take suggestions for improving the current situation both locally and nationally.

These are some of the suggestions so far:

- the media should be used as a tool to raise awareness about the reality of CPR in hospitals
- GPs become more involved in making decisions with patients in residential homes – this may help if the patient is admitted into hospital
- information leaflets should be developed for patients and relatives (currently in draft form)
- nationally – should all patients be asked whether they wish to be resuscitated on admission?
- the trust policy should be read by all concerned and used as a working document
- there is room for further clinical audit
- more patient involvement in the development of leaflets
- a suggestion was made that a system be developed nationally of 'scoring' the patient's chances of being successfully resuscitated depending on their clinical condition

CONCLUSION

Our society seems to encourage the attitude that death is an unacceptable outcome for almost everyone under almost any circumstances. This adds to the difficulties of the resuscitation team. DNAR remains a controversial issue. Resuscitation remains aggressive by its very nature. In order to move forward there needs to be more public understanding surrounding resuscitation. Aldous Huxley wrote: 'Death . . . it's the only thing we haven't succeeded in completely vulgarising.'

I wonder.

REFERENCES

- 1 NHS Executive. Resuscitation Policy (HSC 2000/028). London: Department of Health, September 2000
- 2 Revised Joint Statement from the BMA, Resuscitation Council (UK) and the Royal College of Nursing. Decisions relating to cardiopulmonary resuscitation. 1999
- 3 Wagg A, Kinirons M, Stewart K. Cardiopulmonary resuscitation: doctors and nurses expect too much. J Roy Coll Phys Lond 1995;29(1):20-24
- 4 The NHS Plan – an action guide for nurses, midwives and health visitors Dept of Health March 2001
- 5 Saunders J. Perspectives on CPR: resuscitation or resurrection? Clin Mid 2001;1(6):457-60

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