Ethical, professional, and legal obligations in clinical practice: a series of discussion topics for postgraduate medical education

Topic 3: resuscitation decisions in adult patients

D M Gore

This is the third discussion topic in a series of five dealing with ethical, professional, and legal obligations of clinical practice. Junior doctors tend to lack confidence in these subjects, and thus I organised a series of informal discussions in our surgical unit on which these articles are based. The sessions were prepared with reference to non-academic literature readily available from the General Medical Council and the medical defence organisations. While our unit dealt with these issues from a surgical perspective, the obligations of clinical practice apply to all practitioners, and the series could be easily modified for other clinical specialties.

Closed chest resuscitation for cardiopulmonary arrest was pioneered in the 1960s and a crash team is now a standard feature of UK acute hospitals.¹ Different series report survival rates ranging from 5%–20%. A “not for resuscitation” (NFR) decision indicates that an elective decision has been made not to call the crash team if in the future that patient stops breathing or suffers cardiac arrest. Resuscitation decisions are very emotive and have been the subject of much media interest.

Every unit should have a resuscitation policy because inappropriate resuscitation may:

- Be contrary to the expressed wishes of the patient.
- Unnecessarily commit intensive care unit facilities.
- Deny the patient a dignified death.
- Cause distress for relatives.
- Cause cynicism and dissatisfaction among the medical and nursing staff.

There is little case law directly dealing with resuscitation, although many of the principles of consent to treatment apply. Resuscitation guidelines are in general drawn from basic ethical and professional principles.

When is a NFR decision indicated?

If the patient *spontaneously requests* that resuscitation not be performed, then that request should be respected as any other.² Such a request should be evaluated for consistency and good sense. A one-off comment by an ill patient on the intensive care unit who actually stands a good chance of a full recovery should not precipitate a NFR decision until he/she has been carefully counselled about the prognosis.

There are certain *clinical indications* for a NFR decision:

- If the patient is a dying patient, one whose treatment has already been changed from

that which prolongs life to that of palliating a certain and imminent death.

- If there is such comorbidity that resuscitation is extremely unlikely to be successful¹: hypotension with heart failure, significant acute renal failure, severe pneumonia, metastatic malignant disease. Elements of comorbidity which are irreversible or rapidly progressive are particularly significant.
- Age itself is NOT a contraindication for resuscitation.

A NFR decision is indicated if resuscitation is not in the patient's *best interests*²—either when a lucid patient reasonably states their quality of life is intolerable, or if the perceived quality of life for a legally incompetent patient is very poor. Estimation of quality of life and best interests in such cases demands the careful consideration of senior clinicians.

Making a NFR decision

If a NFR decision is indicated, consensus should be sought, the patient's autonomy being the paramount consideration.^{2,3} Doctors tend to underestimate how willing people are to talk about their own death.

Only when consensus is reached can a NFR decision actually be made. If there are strong medical contraindications for resuscitation, a stark choice should not be presented. A choice is simply too onerous and may not reflect the reality of the situation. A recommendation should be made and consensus sought.

The NFR decision should be made by a consultant if possible⁴; if made by a registrar or staff grade doctor it should be ratified as soon as possible with the consultant in charge. It should be carefully documented along with indications in the notes, but there should be no visible badge of NFR status about the patient.

Counselling relatives and carers

Relatives should be kept informed of decisions to the extent that this disclosure is acceptable to the patient. Just as in consent for a procedure, they cannot give proxy consent but naturally their views are very important if the patient is legally incompetent.

Communicating the NFR decision

Nursing staff must be involved in decision making; it is often nursing staff who first witness an arrest. Understandably there will be a “default decision” to call the crash team

Craigavon Area
Hospital, Northern
Ireland
D M Gore

Correspondence to:
Mr D M Gore, Department
of Surgery, University of
Liverpool, 5th Floor UCD
Building, Daulby Street,
Liverpool L69 3GA, UK
dmgore@liverpool.ac.uk

Submitted 24 May 2000
Accepted 2 August 2000

unless the NFR decision is discussed daily in the ward round among medical and nursing staff.

What if resuscitation is specifically requested?

If resuscitation is specifically requested by a patient, this should be respected even if a successful resuscitation is unlikely.

Advance directives

Advance directives are now considered valid by the General Medical Council so long as the circumstances anticipated in the advance directive are applicable to the now-confused patient and there is no reason to believe that the patient changed his/her mind.²

Case example

Mr E is 75 years old and has diabetes. He has progressive gangrene of the foot which absolutely requires amputation. He has severe refractory congestive cardiac failure and is breathless even sitting up in bed, with a systolic

blood pressure of 90 mm Hg. He is a very poor anaesthetic risk. He is not sure whether he can face an amputation. Should resuscitation status be discussed?

- A resuscitation decision is most desirable here. His prognosis is very poor and on medical grounds resuscitation is contraindicated. He should be counselled of the good sense of a NFR decision and consensus sought. He must be reassured that this does not mean active treatment will be discontinued and the NFR decision itself has no bearing on any future decision about amputation.

With thanks to Mr C Weir FRCS and Mr I Stirling FRCS, Craigavon Area Hospital.

1 Bedell SE, Delbanco TL, Cook EF, *et al.* Survival after cardiopulmonary resuscitation in the hospital. *N Engl J Med* 1983;**309**:569–76.

2 General Medical Council. *Seeking patients' consent*. London: GMC, 1998.

3 General Medical Council. *Good medical practice*. London: GMC, 1998.

4 Medical Defence Union. *Consent to treatment*. London: MDU, 1997.