

# Reducing futile attempts at resuscitation

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A recent review in the *BMJ* has drawn attention to major concerns about 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms.<sup>1</sup> One of these concerns is with the distressing number of deaths that are surrounded by futile attempts at cardio-pulmonary resuscitation (CPR). Such attempts occur for a number of reasons. Some patients with terminal illnesses, or who are elderly and frail, do not have a form, perhaps because their doctors were too busy or never got round to raising the issue. Other patients may have deteriorated very soon after admission, or more quickly than anyone expected, so that no-one had a chance to discuss their wishes with them in advance. A few patients may have refused consent to having DNACPR on their records because of their beliefs, in spite of having diseases likely to lead to death. In all these circumstances, doctors who are called at the time of death will typically feel they have no authority to withhold CPR, or they fear the legal risks of doing so – in spite of knowing that what they are doing is pointless. Their fear is understandable. In the UK, the guidance from the Resuscitation Council states that should be an initial presumption in favour of CPR<sup>2</sup> and regulators continue to impose sanctions on clinicians who decided not to resuscitate patients who had been dead for some time<sup>3</sup>

There do not appear to be any studies of how often such attempts take place, but narrative accounts of them are common.<sup>4,5</sup> The injuries that patients sustain during such attempts include broken ribs, tracheal damage from intubation, and extensive bruising – along with a profound loss of personal dignity. Although patients in these circumstances are unlikely to be conscious of these effects, one physician has suggested that futile CPR may be tantamount to assault and might constitute torture under the European Convention on Human Rights<sup>6</sup> Whether or not this is the case, families who witness these attempts, or the results of them, can be traumatised. Conversely, if families happen to be absent during a failed attempt, they may never be

told of these injuries, raising an equally serious ethical concern. The effects of such failed attempts on the doctors and other staff who carry them out can also be harrowing.<sup>7</sup>

Some of the remedies for this state of affairs are clear. Every consultant should emphasise the importance of DNACPR forms and encourage teams to make them a priority. Educators can train junior doctors about how to hold more candid conversations with patients and families so they make more informed decisions. Hospitals should monitor the frequency of failed attempts at resuscitation and review these to see how many could have been avoided. Beyond these practical changes, however, there is clearly a need for an alteration in mind-set about the nature of resuscitation and of death itself.

## CARDIAC ARREST AND ORDINARY DYING

One good starting point is to recognise that hospitals nowadays are mostly full of people with multiple comorbidities who at some point are going to die from these, even if the date cannot be predicted with accuracy. When they do so, their hearts will stop. This kind of ordinary dying (which most of us are likely to undergo) is entirely different from cardiac arrest as commonly understood, and for which CPR procedures are designed.<sup>8</sup> Ageing patients who are approaching such deaths need a compassionate explanation that chest compressions and electric shocks will never restore their failing organs, and the purpose of a DNACPR document is simply to spare themselves the indignity of such acts. As many doctors have argued, it is then far more important for the conversation to focus on advance care planning to ensure that patients' remaining years, months or weeks are spent in the way they would wish.<sup>9</sup>

In the same spirit, we should encourage medical students and junior doctors to recognise CPR for what it is: a medical intervention with clear indications and contra-indications, just like any other treatment. It has a reasonable success rate in isolated cardiac arrest, but a 'miserable' one in deaths arising from other causes.<sup>10</sup> Just as no-one would consider prescribing chemotherapy for ischaemic heart disease,

it is unreasonable in most instances to administer CPR in patients who are dying as a result of cancer or other non-cardiac causes.

There are several standard tools for assessing the likelihood of a successful resuscitation. Although none of these are sensitive enough in themselves to determine CPR decisions<sup>11</sup> they can be combined with other measures including clinical frailty<sup>12</sup> to aid discussions with patients and families. Some hospitals have already replaced DNACPR forms with one offering the positive option 'Allow Natural Death' (AND)<sup>13</sup> Other alternatives include the 'Universal Form of Treatment Options', which has been shown to reduce the risk of staff misinterpreting DNACPR as a reason for withholding interventions that could benefit patients.<sup>14</sup> Logically, it might also make sense to replace the use of DNACPR forms with a positive recommendation for a minority of patients only ('suitable for cardiac compression and electric shock if required').

Finally, a patient's wishes in relation to resuscitation are not legally overriding. So long as patients have been involved in the decision-making process, doctors are not bound to carry out unnecessary and ineffective treatment in relation to CPR, any more than if someone demands any other kind of treatment that is inappropriate and harmful for their condition.<sup>15</sup> Instead of regarding the issue of DNACPR as a legal hurdle, it is time to move on to seeing it as an opportunity to have the kind of conversations with patients and their families that actually need to take place, and for clinicians and regulators to make the right professional judgements when this has not occurred.

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