

Should hospices be exempt from following national CPR guidelines?

Cardiopulmonary resuscitation is traumatic and often unsuccessful in seriously ill patients. **Max Watson** and colleagues argue that current guidelines on its use are unsuitable for hospices, but **Claud Regnard** and **Fiona Randall** believe they ensure all patients get the best care



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YES The patient population in UK hospices is changing. Patients with malignant and non-malignant diseases, increasing disease complexity, and multiple comorbidities are attending from earlier in their illness for management of symptoms and supportive care. Indeed, almost half of hospice patients are now discharged.¹ Yet, despite these trends we must remember that hospice patients have illnesses that are not curable.²

Hospices should be exempt from applying blanket national cardiopulmonary resuscitation guidelines³ because the needs and treatment goals of hospice patients differ from those of patients in other care settings. Instead, the hospice movement should develop its own guidelines, which would take account of patients close to death as well

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those admitted for symptom control and rehabilitation.

Problems with existing guidelines

The joint statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing on cardiopulmonary resuscitation¹ is a helpful step forward but translates disappointingly into the hospice sector. It is not written for, and applies poorly to, the hospice population, where the goal for the majority is quality of life and a dignified death.

In the context of hospices, it is important to clarify the differences between cardiopulmonary arrest and dying (table). Cardiopulmonary arrest is a medical emergency, with potentially reversible causes. Dying, however, is an irreversible natural process in which cardiopulmonary

resuscitation has no chance of success. It may not always be easy to distinguish one from the other, but failure to do so can cause major distress for all involved. If a patient is dying, resuscitation is inappropriate. Discussion of resuscitation with such patients is unnecessary and confusing.

Rather than following the national recommendations that patients can opt out

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NO It is tempting to view hospices as unique therapeutic environments that demand special treatment. However, hospices have no desire to work outside national guidelines on good practice. The current cardiopulmonary resuscitation guidelines¹ uphold essential core principles and values that particularly apply in end of life care and are coherent with the Mental Capacity Act (England and Wales)^{2,3} and the Adults with Incapacity Act (Scotland),⁴ which govern decisions for patients who lack capacity. The guidelines reflect the good practice expected of hospices.

Protection against arbitrary discrimination

The guidelines provide essential protection against discrimination on irrelevant grounds. When a cardiorespiratory arrest is expected, and an advance decision is needed, the guidelines ensure this decision is tailored to the individual

and to their circumstances, and not to arbitrary factors such as place of care.

When a cardiorespiratory arrest occurs unexpectedly, the guidelines state that there should be an initial presumption in favour of cardiopulmonary resuscitation unless the patient has a valid and applicable anticipatory decision refusing it. Therefore the new guidelines protect patients from arbitrary discrimination and protect their right to receive cardiopulmonary resuscitation.

They also promote a welcome return to common sense clinical practice by experienced clinicians. For example, a do not attempt resuscitation (DNAR) decision does not override clinical judgment if the patient has a reversible cause of arrest that does not match the circumstances envisaged in the decision (such as secretions blocking a tracheostomy tube). Hospice patients should not be exposed to unjust discrimination by policies that are inconsistent with the national guidelines (such as a default not to attempt cardiopulmonary resuscitation).

Protection of patient choice

When an arrest is expected and cardiopulmonary resuscitation has a realistic prospect of success, the guidelines require professionals to offer it even if they judge that the harms and risks might

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of cardiopulmonary resuscitation, it would be more appropriate for hospices to have a policy of opting in. Although some people may feel this leaves hospices open to the charge of “giving up” on patients, the minimal likelihood of a patient being discharged after successful resuscitation makes such a stance more sensible and sensitive.

The guidelines make no reference to the clinical decision that is most likely positively to affect the outcome for hospice patients requiring cardiopulmonary resuscitation—that is, if the risk of needing resuscitation increases, whether it would be appropriate to transfer them to an acute hospital that has the facilities to maximise the chances of preventing cardiopulmonary arrest or for full resuscitation. Sometimes patients at high risk of arrest are not transferred because, even after full explanation, they choose not to leave the hospice or they are already getting maximum appropriate therapy, or they are too unwell to transfer. In these cases resuscitation is clearly inappropriate.

Considered approach

The guidelines also leave important questions unanswered—for example, how you weigh up the benefits versus the risks and make a valid assessment of the likelihood of success in patients who have

outweigh the benefits. Palliative care teams and services are increasingly caring for patients with life limiting illness other than cancer, and patients with life threatening cancer are living longer. In some of these patients cardiopulmonary resuscitation has a realistic prospect of success and should be attempted if the patient wants or would have wanted it. There is no justification for exempting hospices from offering cardiopulmonary resuscitation in this situation, even though their staff might provide only basic life support with an immediate call for appropriate emergency services.

The guidelines are equally protective of patients who have made a valid advance refusal of cardiopulmonary resuscitation, as required by UK law. The guidelines also make clear that both groups of patients (or their relatives if the patient lacks capacity) have the right to an informative discussion on cardiopulmonary resuscitation in their case. The protection of patient choice and effective communication of relevant information are cornerstones of effective hospice care. It makes no sense to seek exemption from guidelines that protect these rights.

no possibility of cure. More research is needed to answer these questions, but in the meantime any guideline on decisions about cardiopulmonary resuscitation in hospices must highlight at least two key issues.

Firstly, as in the current national guideline, it should emphasise that cardiopulmonary resuscitation describes only attempts to achieve return of spontaneous circulation. It does not refer to the treatment of any other life threatening conditions such as anaphylaxis, or to decisions concerning hydration, nutrition, or antibiotics. Thus decisions around cardiopulmonary resuscitation should be seen in the context of a medical emergency and not end of life decisions. Equally a do not attempt resuscitation order does not apply to any decisions except those relating to cardiopulmonary resuscitation¹; such an order does not mean do nothing.

Secondly, the guideline must encourage timely and appropriate discussion with patients to ascertain their wishes. This is always good practice, but it seems disingenuous to ask patients whether they want cardiopulmonary resuscitation if full facilities are not available. In reality many hospices offer something similar to that currently available in a supermarket or an airport (basic life support while awaiting a

Protection of patients who lack capacity and dying patients

The guidelines ensure that when the patient has lost capacity, either before or at the point of cardiorespiratory arrest, the decision regarding resuscitation will be determined by the patient's best interests. Importantly for hospices the guidelines also protect patients from being subjected to cardiopulmonary resuscitation if

there is no realistic prospect of success. Even if no prior decision has been made, the guidelines instruct that resuscitation should not be attempted or continued if

it is clear that it could not be successful. In such patients the guidelines are clear that it is inappropriate to initiate a discussion about cardiopulmonary resuscitation. These safeguards are essential to prevent unnecessary distress for patients, partners, and relatives at the end of life.

Exemption equates with exclusion

Palliative care teams work in almost every clinical environment and setting. It is essential that these teams understand the ethical, legal, and clinical basis of cardiopulmonary resuscitation

Differences between dying and cardiopulmonary arrest

Dying	Cardiopulmonary arrest
A process	An event
Natural and expected	Medical emergency
Diagnostic criteria include lack of pulse and respirations	Diagnostic criteria are lack of pulse and respirations
Preceded by progressive decline in condition	Sudden event in the context of relative stability
Deterioration despite maximum appropriate medical treatment	Further appropriate medical treatments available
Irreversible underlying cause	Potential to improve the underlying cause
CPR has no realistic chance of success	CPR has a realistic chance of success

cardiac ambulance), though often without the defibrillator. True respect for patient autonomy requires that discussions about these issues take place before patients enter the hospice system.

Decisions about cardiopulmonary resuscitation are often complex, challenging, and emotive. The context of the decision making is key. One national policy for all healthcare contexts is too ambitious. A specific hospice guideline that is clear, simple, and robust, with accompanying implementation training for staff, needs to be developed as a priority.

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decisions. Working to different rules in hospices would result in confusion, exclude hospice patients from recognised good practice, and would seriously compromise working partnerships with colleagues in other settings. Exemption would create poorer, and thus inequitable, care for hospice patients.

In the UK, inpatient hospices either function under NHS regulations or are registered as independent hospitals under the regulations of the Commission for Social Care Inspection. Both bodies require hospices to have policies on cardiopulmonary resuscitation that follow the advice of the UK Resuscitation Council, currently expressed through the UK guidelines. The proposal that hospices should function outside the national guidelines is the antithesis of hospice aspirations to excellence of care, patient choice, equity, and to effective partnership with other specialties in all care settings. It is inconceivable that hospices should seek exemption from the good practice set out in the UK guidelines.

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All references are in the version on bmj.com