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Research

Barriers to implementing a policy not to attempt resuscitation in acute medical admissions: prospective, cross sectional study of a successive cohort

H Fidler, C Thompson, A Freeman, D Hogan, G Walker, J Weinman

Abstract

Objective To establish whether acutely unwell patients admitted to hospital wish to participate in discussions about resuscitation.
Design Prospective, cross sectional study of a successive cohort of patients.
Setting Admission through the emergency department.
Participants 374 adult patients.
Main outcome measure Whether acutely unwell patients wished to participate in discussions about resuscitation.
Results Of the total sample, 74 patients consented to take part in the study and provide full data. Of the remaining patients, 189 could not be approached for practical reasons and 111 did not wish to participate. Of the 74 patients who read the leaflet, 65 (88%) reported having little or no prior knowledge, 70 (96%) understood it, 56 (77.8%) preferred for resuscitation decisions to be discussed with them, and 55 (77.5%) did not mind discussing resuscitation within 24 hours of admission and overall showed a decline in their anxiety score.
Conclusion Many patients admitted through the emergency department for medical reasons cannot participate in their decision not to attempt resuscitation within 24 hours of admission. Patients who were willing to participate rated the information leaflet that was provided positively.

Introduction

Written resuscitation policies began to appear in hospitals in the 1990s after public concern about the fact that "do not resuscitate" orders were being written in patients' notes without their knowledge or consent. Current guidelines advocate the explicit discussion of resuscitation status with all competent patients and their relatives unless a clear reason exists why this would not be in the patient's best interests.[1] However, implementation of these guidelines has been found to vary greatly between hospitals,[2] and difficulties in implementing an effective resuscitation policy in our hospital for patients admitted through the emergency department on medical "take" prompted us to see why this was so.

Previous studies have shown that seriously ill patients wish to be involved in end of life decisions, and active participation of patients is now widely applied in other treatment decisions, with great success.[3 4] Acutely ill patients have rarely been included in previous studies, and waiting until they have partly recovered before seeking their views may result in their being excluded from the decision. We investigated what prevents patients admitted acutely from being questioned about their views: practical difficulties or a genuine increase in anxiety for these patients that discourages medical staff from raising the issue.

Methods

We approached a prospective unselected sample of 374 adult patients admitted acutely under the medical team on call and without cognitive impairment or psychiatric problems shortly after arrival in the emergency department. They were given a standardised verbal and written explanation of the study. After 24 hours they were asked if they wished to participate and to provide written consent if they did. Patients who declined were asked if they minded giving a reason, and we recorded these. Participants completed an abbreviated state trait anxiety inventory,[5] read an information sheet about resuscitation based on the BMA model leaflet, and then completed the inventory again and some items assessing their preferences for cardiopulmonary resuscitation.

Results

Only 74 (20%) patients agreed to discuss cardiopulmonary resuscitation and accept information about it. Of the remainder, 189 (51%) patients could not be approached for practical reasons and 111 (30%) refused to discuss resuscitation. The table shows the reasons why patients could not be approached and the reasons for declining. Of the 74 patients who read the leaflet, 65 (88%) reported having little or no prior knowledge, 70 (95%) understood it, 56 (76%) preferred that resuscitation decisions were discussed with them, and 55 (74%) did not mind discussing resuscitation within 24 hours of admission and overall showed a decline in their anxiety score.

Discussion

Eighty per cent of patients admitted through the emergency department for medical reasons cannot participate in their decision on resuscitation within 24 hours of admission. For many, this is for unavoidable practical reasons, such as confusion or severe illness. For others, it was the availability of a translator, the patient being absent when the discussion was planned, or the patient having no glasses to read the information sheet. Once these difficulties have been identified, we can focus on them and correct them. Yet aside from practical reasons for not participating, many patients chose not to discuss this aspect of their care at this stage, and for most this was because of the subject matter.

For these patients it is unfair to assume that paternalism is driving the failure of implementing a policy not to attempt

Reasons for non-inclusion of patients in the study

	No (%)
Reason why patients could not be approached for inclusion in the study	
Dementia	16 (8)
Confusion (medical reasons)	15 (8)
Insufficient English to understand the consent form	12 (6)
Other medical reasons	83 (44)
Off ward	28 (15)
On family's request	3 (2)
Gone home	13 (7)
Transferred to another hospital	1 (0.5)
Psychiatric history	3 (2)
Visitors	0
No reason noted	15 (8)
Totals	189 (100)
Reasons given by patients for not wanting to participate in the study	
The subject matter (reported by the patient)	15 (14)
The subject matter (opinion of researcher)	26 (23)
Tired or feeling too ill	20 (18)
Other worries	2 (2)
Had not read the consent form	4 (4)
Asleep	2 (2)
Had visitors	5 (5)
Discharged	12 (11)
No glasses	3 (3)
Not on ward	3 (3)
No reason given	14 (13)
Family did not want patient to take part	5 (5)
Totals	111 (100)

resuscitation. We must ask our patients if they wish to be involved, and until they feel well enough, health professionals continue to carry the responsibility for decisions on resuscitations.

Contributors: The study's outline and method were developed by HF, JW, and CT. Research was collected, collated, analysed, and evaluated by CT, AF, and DH, under the supervision of HF, and JW oversaw the project. JW, HF, AF, and DH contributed to the writing of the report. JW is the guarantor.

Competing interests: None declared.

Ethical approval: Guy's Hospital Ethics Committee.

1 BMA, Resuscitation Council (UK), Royal College of Nursing. *Decisions relating to cardiopulmonary resuscitation. Joint statement.* 2002. www.bma.org.uk/ap.nsf/content/cardioresus.

2 Cauchi L, Vigus J, Diggory P. Implementation of cardiopulmonary resuscitation guidelines in elderly care departments: a survey of 13 hospitals shows wide variability in practice *Resuscitation* 2004;63:157-60.

3 Kirk P, Kirk I, Kristjanson LJ. What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study. *BMJ* 2004;328:1344-8.

What is already known on this topic

Current guidelines on resuscitation advocate discussion of resuscitation with all patients who have the capacity for involvement

The proposed optimal time to discuss resuscitation with patients is within 24 hours of acute medical admission

However, it has been shown that this is not happening, and the presumption has been that this is because time constraints and doctors' reluctance to cause patients anxiety

What this study adds

During a typical medical "take," half the patients admitted were unable to partake in resuscitation discussions within 24 hours of admission, and most of the remainder chose not to

Of those patients who consented to participate, most did not mind discussing resuscitation, and anxiety was found to decrease in patients after discussing resuscitation, suggesting that resuscitation discussions within 24 hours of admission is indicated

To include more patients in their decision, doctors should be focusing on the practical difficulties and patients' preferences as shown in the first 24 hours of admission

4 Vedula KC, Ganti SN, Schears RM. Advanced directives in an emergency department nonagenarian population. *Ann Emerg Med* 2004;4(S1):S68.

5 Marteau TM, Bekker H. The development of a six item short form of the state scale of the Spielberger state trait anxiety inventory (STAI). *Br J Clin Psychol* 1992;31:301-6.

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Department of Gastroenterology, University Hospital Lewisham, London SE13 6LH
H Fidler *consultant*

Psychology Department (Health Psychology Section), Institute of Psychiatry, London SE5 8AH
C Thompson *medical student*
A Freeman *medical student*
D Hogan *medical student*
J Weinman *professor*

Emergency Department, University Hospital Lewisham
G Walker *staff grade*

Correspondence to: J Weinman john.weinman@kcl.ac.uk