ACUTE PERSPECTIVE

VIEWS AND REVIEWS

David Oliver: Resuscitation orders and reality

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The BMJ recently carried two informative pieces on the implications of common law rulings for doctors in England and Wales documenting “Do not attempt cardiopulmonary resuscitation” (DNACPR) decisions.^{1 2} The *Tracey* ruling in the Court of Appeal was followed by *Winspear* in the High Court.^{3 4} Responses revealed many professional concerns about the implications. Meanwhile, the Resuscitation Council recently consulted on “Emergency care and treatment plans”: these aim to make recorded anticipatory decisions about patients’ wishes and the desirability and limits of emergency and life saving treatment more consistent and widespread, including in people who lack capacity.⁵

It’s easy to see why the public and press can become so agitated. Finding out second hand that you or your loved one has been made “DNACPR” without your involvement can be shocking and can ruin trust.⁶ But there are two sides to ethical slippery slopes, and laws can have unintended consequences.

Acute adult hospital care gets more pressurised as demand rises inexorably. Patients increasingly have frailty, dementia, or long term conditions that limit life expectancy and the chance of successful CPR.⁷

We’re now legally obliged to discuss DNACPR decisions with patients. Failing that, we must make all reasonable efforts to speak to families, however inconvenient or upsetting, and however futile, we think CPR may be. Communicating and explaining a DNACPR decision won’t usually change it. If anything, I can see more people saying they don’t want CPR.

On the acute take, a small handful of patients will have existing DNACPR orders or documented advance decisions. Some will be capable of discussing CPR in the melee of the hospital emergency floor but, already unsettled by being admitted, are often disconcerted by our asking. We may lack the time for a considered, sensitive discussion.

Many patients will lack the immediate capacity for that discussion. Some will have relatives with them to discuss CPR. Others may not, so we must discuss on the phone, or in person despite transport or distance. It’s often hard to get hold of people or their numbers, even in emergencies.

We have other priorities—treating sick people, dealing with equally important new patients arriving, discharging others to free beds. These may have to come before phone calls—especially in understaffed departments.

I strongly predict that some staff, motivated by genuine concern for patients, will continue to make them “DNACPR” without family discussions. More court cases will arise. More patients will be “For CPR” until they’re on a ward and a discussion can be had, perhaps days later. Crash teams will be called to patients’ bedsides, wonder what they’re doing there, and end up feeling obliged to start CPR.

Most in-hospital CPR fails, and outcomes are often poor for survivors.⁸ Those of us who have witnessed and delivered it know how undignified, even brutal, it can be. Broken ribs, burns, intubation, repeated cannulation, hypoxic brain damage. Tellingly, most doctors wouldn’t choose this for themselves.⁹

I don’t advocate law breaking. But campaigners and courts might be realistic about the competing demands on a depleted, pressured workforce and a realisation that well intentioned rulings may risk harms to many patients.

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- 2 Etheridge Z, Gatland E. When and how to discuss “do not resuscitate” decisions with patients. *BMJ* 2015;350:h2640.
- 3 R (Tracey) v Cambridge University Hospital NHS Foundation Trust and another. [2014] EWCA Civ 822, [2012] EWHC 3860 (Admin).
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