



## VIEWS AND REVIEWS

### ACUTE PERSPECTIVE

# David Oliver: Why I'm changing my mind about resuscitation

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I've written before about planning end of life care,<sup>1</sup> pragmatism in decisions regarding "do not attempt cardiopulmonary resuscitation" (DNACPR), and possible dissonance between legal rulings and clinicians' daily realities.<sup>2</sup> I've called for more measured media reporting and said that dying people need protection from undignified, distressing medicalised intervention.<sup>1,3</sup>

My columns and others on DNACPR have elicited many responses,<sup>4,5</sup> notably from Kate Masters,<sup>6,7</sup> whose father's action led to the Tracey judgment. Kate has been contacted by many families with similar stories.

A memorable letter described resuscitation as "the routine, institutionalised electrocution and torture of the dying" (BMA Newsletter, June 2016). Some people understandably prefer the term "allow natural death" to "DNACPR."<sup>8</sup>

I've been contacted by doctors sharply distinguishing between resuscitation in people with life limiting conditions and in fit people with sudden unexpected illness or injury. I've read preliminary research from Scotland finding that many older inpatients were perfectly willing and able to discuss limits of treatment.<sup>9</sup>

I've reflected on analogies between DNACPR and other medical interventions—despite its special status as an immediate lifesaving treatment that can be initiated anywhere and by anyone.

For hospital inpatients and care home residents, we should do all we can to avoid CPR without patient consent or best interest discussions with families

For registered practitioners, common law precedent already protects us in acting without patient consent in life threatening situations when time won't allow otherwise.<sup>10</sup> But, for most patients entering hospital, the possibility of resuscitation could reasonably be anticipated and planned for.

Consent law means that clinicians must disclose a reasonable degree of information on the risks and benefits of medical interventions.<sup>11</sup> Compressions, intubation, cannulation, powerful drugs, and electrical shocks are surely such interventions.

Informed consent for CPR would also need discussion of success rates, injuries, anoxic brain damage, intensive care admission, and ventilation—and the patient's own goals if he or she survives.

I'm coming gradually to a view that, for hospital inpatients and care home residents, we should do all we can to avoid CPR without patient consent or best interest discussions with families. Documenting CPR status for all patients would also remove the ambiguity when a crash team arrives at the bedside and finds no form. Is the decision to attempt resuscitation deliberate or an oversight?

Doctors are under no obligation to offer CPR on demand if it would be futile or harmful, but documenting the decision for every patient could ensure that it's been explained and that no patients or families are taken by surprise.

I don't underestimate the difficulties in realising this. Competing pressures and priorities may cause perfunctory, rushed, poorly understood, or distressing discussions and take valuable time from other work. But I do welcome further debate, including any sparked by related articles in this issue of *The BMJ*, and the Resuscitation Council's ongoing "Emergency Care and Treatment Plan" (RESPECT).<sup>12</sup>

Competing interests: See [www.bmj.com/about-bmj/freelance-contributors/david-oliver](http://www.bmj.com/about-bmj/freelance-contributors/david-oliver).

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