# The Decision to Withhold Resuscitation in Australia: Problems, Hospital Policy and Legal Uncertainty

*Decisions to withhold cardio-pulmonary resuscitation (CPR) should provide explicit clinical and ethical justification, be stated in an unambiguous manner, and be formally documented in the medical chart. Even so, the legal status of decisions to withhold CPR remains uncertain, in part because there is all too often no written justification for a No-CPR order; no statement of the overall management plan subsequent to an order; no indication of who made the decision; no explanation as to what may lead to changes in the decision; and no reference to the wishes of the patient, family or surrogate. The fact that hospital policies regarding No-CPR orders are rare or are ignored may be symptomatic of failures in communication between physicians on the one hand and the patient and the health care team on the other. Communication failures often mask paternalism and concepts such as "futility" and "medical indications" are used to override patient autonomy in decisions regarding cardio-pulmonary resuscitation. In Newcastle, Australia, a recent review of current CPR practice and its ethical implications led to the formulation of policy guidelines concerning the problems of when to initiate CPR and when and how No-CPR orders should be issued.*

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## Resuscitation

Following the invention of closed-chest cardiac massage in 1960,[1] cardio-pulmonary resuscitation (CPR) was originally applied to victims of cardio-respiratory arrest following acute myocardial infarction, surgery, cardiac arrhythmias, electrical shock, drowning, drug overdose and anaesthetic accidents. Since then, however, it has been applied much more widely in the clinical setting and is commonly carried out on almost any patient who suffers a cardio-respiratory arrest.[2] Can such wide application still be ethically justified in the hospital context? The clinical reality is that while 30 to 50 per cent survive the initial resuscitation, only 5 to 23 per cent (an average of 13 per cent) survive to hospital discharge.[3] Further analysis reveals a consistent clinical dichotomy: patients with chronic, debilitating illness rarely survive to hospital discharge (0 to 4 per cent) after CPR,[4] whereas otherwise-well patients who experience an acute coronary event have a much greater chance (12 to 40 per cent) of

[1] W B Kouwenhaven, J R Jude and G G Knickerbocker, "Closed-chest Cardiac Massage" (1960) 173 *Journal of the American Medical Association* 1064.

[2] J T Neimann, "Cardio-pulmonary Resuscitation" (1992) 327 *New England Journal of Medicine* 1075.

[3] C F Von Gunten, "CPR in Hospitalized Patients: When Is It Futile?" (1991) 44 AFT 2130.

[4] D J Murphy, "Do-not-resuscitate Orders: Time for Reappraisal in Long-term-care Institutions" (1988) 260 *Journal of the American Medical Association* 2098.

surviving to discharge. Indeed, it is clear that clinical outcome after CPR is strongly correlated with underlying illness and that patients with certain conditions rarely survive.[5] Several studies have demonstrated that age *alone* may not be a determinant of survival after CPR,[6] although this remains uncertain as there is some evidence to suggest that age greater than 70 years may be a prognostic indicator.[7] Furthermore, aside from potential benefits, CPR, as with any other form of medical intervention, has considerable potential burdens such as rib fractures, multiple venepunctures, prolonged intensive care unit admission and the persistent vegetative state, estimated in some studies to be 2.7 per cent.[8]

## The omission of CPR

Concern that the initiation of CPR may not be medically or ethically justifiable in certain situations and that decisions regarding the application or the withholding of CPR are often made without justification and/or patient and family input, have led to the development of guidelines regarding the *omission* of CPR. These have been variously recorded as DNR (Do Not Resuscitate), NFR (Not for Resuscitation), GPC (Good Palliative Care), and No-CPR orders. The development of institutional guidelines does not in itself guarantee that existing legal and ethical difficulties will be resolved.

## Problems with documentation

In a recent study carried out in Australia, analysis of DNR orders in one hospital over a three-month period revealed that 84 per cent were *not* documented in accordance with the wording recommended in its hospital policy.[9] This is an important finding as proper understanding or interpretation of a No-CPR order is difficult, if not impossible, without a clear and unambiguous statement of the No-CPR order and the rationale behind it. However, there is often no written justification for orders to omit resuscitation.[10] Indeed, a recent English survey showed that only a quarter of the patients determined as unsuitable for CPR had No-CPR orders written in their notes.[11] In addition, there was no explanation as to what factors might change the decision, no reference to the wishes of the patient, family or surrogate, and/or no statement of the overall management plan subsequent to the order.[12] By any standard, No-CPR notation is often cursory, ambiguous and frequently neglected altogether. This seems particularly to be the case in large teaching hospitals, where the risk of misinterpretation increases exponentially with the number of health care professionals involved in primary care.

## Problems involving patients and families in resuscitation decisions

Ethically and legally, the fact that medical opinion judges a competent patient's refusal as "unreasonable" does not lessen or remove the patient's right to make such a decision. Most ethicists and physicians agree that respect for the patient's capacity to make a competent and autonomous choice should be a primary factor in

[5] J La Puma, M Silverstein, C Stocking, D Roland and M Siegler, "Life-sustaining Treatment: A Prospective Study of Patients with DNR Orders in a Teaching Hospital" (1988) 148 *Archives in Internal Medicine* 148.

[6] R M Keating, "Exclusion from Resuscitation" (1989) 82 *Journal of the Royal Society of Medicine* 402.

[7] P J Podrid, "Resuscitation in the Elderly: A Blessing or a Curse?" (1989) 111 *Archives in Internal Medicine* 193.

[8] J P Krischer, E G Fine, J H Davis and E L Nagel, "Complications of Cardiac Resuscitation" (1987) 92 *Chest* 287.

[9] D P Stanley and D P Reid, "Withholding Cardio-pulmonary Resuscitation: One Hospital's Policy" (1989) 151 *Medical Journal of Australia* 257.

[10] K Stewart, K Abel and G S Rai, "Resuscitation Decisions in a General Hospital" (1990) 300 *British Medical Journal* 785.

[11] E J Aarons and N J Beeching, "Survey of 'Do Not Resuscitate' Orders in a District General Hospital" (1991) 303 *British Medical Journal* 1504.

[12] H L Lipton, "Do-not-resuscitate Decisions in a Community Hospital: Incidence, Implications and Outcomes" (1986) 256 *Journal of the American Medical Association* 1164.

decisions which determine that patient's resuscitation status.[13] Yet when it comes to *actually* making the decision, the patient—the person whose life is most affected—is seldom involved in the end-of-life decision to resuscitate or not resuscitate.[14] Why is this so, given that it is a violation of the patient's right and exposes the physician to potential legal problems?[15]

## *Paternalism*

One reason may be paternalism. In its most ethically acceptable form, the physician seeks to protect the patient from harm by making decisions for the patient. In the case of CPR or No-CPR decisions, it is argued that patients would rather not know that they are dying or, if aware of it, would prefer not to discuss it with others.[16] The belief that patients would rather avoid such discussions and be shielded from the implications of their disease process is a questionable one at best, considering the survey data now available.[17] Secondly, the physician may believe that the clinical factors affecting decisions regarding critical life-and-death choices are too complex for patients to understand and deal with.[18] However, for the most part competent patients are well able to make a No-CPR decision when given the relevant information, but are often bypassed in favour of using their family as decision-makers, because some studies have shown some patients as incapable of coping with bad news.[19] In any case, neither physicians nor family members are very good at predicting patients' preferences for or against resuscitation.[20]

## *CPR is "futile"*

In contrast to the above, it has been argued that a physician has no obligation to discuss CPR with a patient, even if competent, where its use has been judged to be medically futile.[21] The argument assumes that the judgment that CPR is futile for a particular patient can always be determined on objective grounds. If CPR is judged futile, some argue, then it justifies a No-CPR order. They furthermore argue that such futility justifies the writing of such an order without the consent of either patient or family. However, in many cases, the determination that CPR is futile is not an objective process but rather relativistic and probability based,[22] and is influenced by the physician's *values*[23] and *assumptions* related to anticipated specific benefits such as survival to discharge.[24] In these cases, the physician's values dominate the risk-benefit calculations as to what is worthwhile and tolerable for the patient. In such a case, the extra days of life gained from CPR are seen as insufficient and the use of CPR as ineffective and futile.[25] The issue, however, is not whether the physician's value judgment should be considered, or should predominate, but that the physician's values should not be the *sole* basis for determining CPR as "useful" or "futile" in all end-of-life decisions. We recognise that there may come a time when "reasonable probability" suggests that there is an extremely low chance of survival and thus it may be reasonable not to administer CPR. Furthermore, there may be cases where the burdens of CPR for the patient are

[13] E H Lowey, "Involving Patients in Do-Not-Resuscitate (DNR) Decisions: An Old Issue Raising its Ugly Head" (1991) 17 *Journal of Medical Ethics* 156.

[14] Keating, op cit n 6; D A Schwartz and P Reilly, "The Choice Not to be Resuscitated" (1986) 34 *Journal of the American Medical Geriatric Society* 807.

[15] L Doyal and D Wilsher, "Withholding Cardio-pulmonary Resuscitation: Proposals for Formal Guidelines" (1993) 306 *British Medical Journal* 1593.

[16] S G Schade and H Muslin, "Do-not-resuscitate Decisions: Discussion with the Patients" (1989) 15 *Journal of Medical Ethics* 186.

[17] Keating, op cit n 6; C J Stolman, J J Gregory, D Dunn and J L Levine, "Evaluation of Patient, Physician, Nurse and Family Attitudes Toward Do-Not-Resuscitate Orders" (1990) 150 *Archives of Internal Medicine* 653.

[18] D Orentlicher, "The Illusion of Patient Choice in End-of-life Decisions" (1992) 267 *Journal of the American Medical Association* 2101.

[19] L V Torian, E J Davidson, H M Fillit, F Gulop and L L Sell, "Decisions For and Against Resuscitation in an Acute Geriatric Medicine Unit Serving the Frail Elderly" (1992) 152 *Archives of Internal Medicine* 561.

[20] R F Uhlmann, R A Pearlman and K C Cain, "Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences" (1988) 43 *Journal of Gerontology* M115.

[21] Murphy, op cit n 4; Doyal and Wilsher, op cit n 15.

[22] R D Truog, "Beyond Futility. Commentary on B S Carter and J Sandling's Decision-making in the NICU: The Question of Medical Futility" (1992) 3 *Journal of Clinic Ethics* 142.

[23] E M Wachter, J M Luce, N Hearst and B Lo, "Decisions about Resuscitation: Inequities among Patients with Different Diseases but Similar Prognoses" (1989) 111 *Annals of Internal Medicine* 525.

[24] Von Gunten, op cit n 3.

[25] T Tomlinson and H Brody, "Futility and the Ethics of Resuscitation" (1990) 264 *Journal of the American Medical Association* 1276.

judged to far outweigh its benefits. At any rate, a central issue is the extent to which the decision to withhold CPR should be based on a shared perception or understanding of what counts as a "reasonable benefit worth pursuing" through CPR.[26]

## Resolving problems through shared decision-making

A competent and well-informed patient, family or surrogate is well able to choose between the option of CPR or No-CPR. The major problem that can arise—choosing CPR when quantitatively futile—can for the most part be avoided by adequate interactional skills and sufficient disclosure of information, and resolved through caring and compassionate counselling.[27] Most competent patients, for example, are aware of their own imminent death, and though the physician may be under no obligation to obtain permission to withhold CPR in such a case, there remains a *moral* duty to explain the limitations of medicine and why health care professionals may be reluctant to accede to patients' requests for CPR. "Futility" may not be as precise a concept as we would like, but despite its limitations it can be a *starting* point for discussing the chances of success following CPR (quantitative), and the patient's values and preferences regarding quality-of-life issues (qualitative). Despite the strong argument and prima facie obligation in favour of respecting the patient's autonomy, time spent appraising the weight of this obligation—vis-à-vis the patient's role in decision-making in the face of undefined statements of futility regarding the use of CPR—would be more constructive if spent informing the patient and ensuring that both the physician and the patient accept the limits of what medicine can do and the inevitability of death. The offer of good palliative care with attention to the control of discomforts which the patient may experience, is a positive step that can be taken and is an appropriate alternative to aggressive action aimed at the maintenance of life at all costs through the inappropriate use of CPR. The notion of "futility", with all its imprecision, may still be used as a starting point for discussion and for continued collaborative decision-making with the patient, family and other members of the patient's health care team.[28] Because No-CPR orders can be a potent source of misunderstanding, and even anger and distress among health care workers, any decision for or against CPR should also be discussed with key health team members. Although ultimate responsibility rests with the primary physician, the involvement of appropriate members of the health care team in the decision-making process may ensure a more coherent management plan. Excluding health care team members from the decision-making process may generate unnecessary tensions which affect both the quality of decisions and staff morale.

## Legal uncertainty and "No-CPR" orders in Australia

Some uncertainty still exists regarding the legal status of decisions to withhold and withdraw medical treatment in Australia, despite the fact that several States (South Australia, Tasmania, Victoria and the Northern Territory) have enacted "natural death" legislation that defines the competent adult's right to refuse life-prolonging

[26] N S Jecker, "Medical Futility: Who Decides?" (1992) 152 *Archives of Internal Medicine* 1140.

[27] Lowey, op cit n 13.

[28] I Kerridge and K R Mitchell, "Missing the Point: Rogers v Whitaker and the Ethical Ideal of Informed and Shared Decision-making" (1994) 1(4) JLM 239.

treatment. In New South Wales, the position of the Crown Solicitor is that

> "where life-saving treatment is withheld or withdrawn from a patient, serious issues of criminal responsibility (including negligence, manslaughter and murder) will arise on the part of individuals involved in the care and treatment of patients".[29]

Since this opinion, recent developments in case law, both in Australia and the United Kingdom, have helped to clarify the medico-legal obligation owed to the patient. In the interim, the widespread use of No-CPR orders appears to proceed on the assumption that the law recognises, albeit sub silentio,[30] that a No-CPR order is appropriate where it conforms to the wishes of the patient or surrogate and where, if provided, CPR would offer no benefit to the patient and would merely prolong the dying process. It has been suggested that a failure to initiate CPR may amount to a criminal act because the decision could lead to the patient's death. However, there are many uncertainties about the application of the criminal law in this context. These include (i) whether the *cause* of death is the underlying illness or the decision not to initiate CPR; (ii) whether the health care workers had a duty of care to initiate CPR; and (iii) whether the criminal law applies when the decision made is not intended to kill, but simply to relieve the suffering of the patient. The legal position is less clear in the case of incompetent patients. However, the law has recognised that there may be cases where the patient's quality of life is so poor that it is appropriate to withhold or withdraw life-sustaining treatment.[31]

In contrast to the position in the United States, which has had institutional policies for DNR orders since 1974,[32] and Britain, where CPR policies are now a topic for debate and specific recommendations,[33] very little debate has taken place in Australia and New Zealand and almost no attempt has been made by legislatures to clarify the specific legal issues raised by CPR orders.

## Hospital policy and "No-CPR" guidelines

Existing institutional policies have failed to demonstrate a change in clinical practice. As a consequence of the persisting ethical and legal uncertainty regarding resuscitation, the Clinical Ethics Committee of the John Hunter Hospital recently developed general guidelines for the *omission* of CPR, that is, No-CPR orders.[34] The term No-CPR was chosen in preference to either DNR, NFR or GPC specifically because it refers to the only intervention being considered for withholding, that is, cardio-pulmonary resuscitation, and because it avoids confusion about the meaning of "resuscitation" and the implications of decisions not to resuscitate. These guidelines (Table 1), specifically address the question of whether to initiate CPR when the patient has a cardio-pulmonary arrest, and the use of No-CPR orders to avoid initiating CPR consistent with appropriate clinical, ethical and legal standards and safeguards. It must be noted, however, that policies by themselves fail, and will continue to fail until they receive institutional support at all levels and are embedded within integrated and coherent educational programmes.

[29] *Proposed Legislation to Give Legal Effect to Directions Against Artificial Prolongation of the Dying Process*, Discussion Paper (Legal Services Branch, New South Wales Department of Health, 1990).

[30] T A Torda and P Gerber, "To Resuscitate or Not, That is the Question" (1989) 151 *Medical Journal of Australia* 91.

[31] See *Airedale NHS Trust v Bland* [1993] 2 WLR 316 at 373, 386; I Freckelton, "Withdrawal of Life Support: The Persistent Vegetative State Conundrum" (1993) 1(1) JLM 35 at 42; D Mendelson, "Jurisprudential Aspects of Withdrawal of Life Support Systems from Incompetent Patients in Australia" (1995) 69 ALJ (forthcoming).

[32] M T Rabkin, G Gillerman and N R Rice, "Orders Not to Resuscitate" (1976) 295 *New England Journal of Medicine* 364.

[33] Doyal and Wilsher, op cit n 15; T H Dent and J H Gillard, "Cardio-pulmonary Resuscitation: Effectiveness, Training and Survival" (1993) 27 *Journal of the Royal College of Physicians of London* 354 (editorial); R Williams, "The 'Do Not Resuscitate' Decision: Guidelines for Policy in the Adult" (1993) 27 *Journal of the Royal College of Physicians of London* 139; D Florin, " 'Do Not Resuscitate' Orders: The Need for a Policy" (1993) 27 *Journal of the Royal College of Physicians of London* 135; British Medical Association, Royal College of Nursing in association with the Resuscitation Council (UK), *Decisions Relating to Cardio-pulmonary Resuscitation* (BMA, London, 1993).

[34] I Kerridge, C Myser, K R Mitchell and J Hamblin, "Guidelines for 'No-CPR' Order" (1994) *Medical Journal of Australia* (in press).

(1) A No-CPR order should always involve appropriate members of the health care team (for example, nurses, allied health professionals, medical staff) in the decision-making, although the final decision remains the responsibility of the senior attending medical officer.

(2) A No-CPR order should be recorded as a formal order in the patient's progress notes in a clear and unambiguous manner.

(3) A No-CPR order should incorporate a brief description of discussions with the patient and/or family members, and

  (a) a statement of the patient's wishes (when the patient is competent) or

  (b) the role of the family/surrogate (when the patient is incompetent).

(4) Where a decision has been made *not* to involve a patient or surrogate in decisions regarding resuscitation status, an explanation should be provided in the progress notes as to the rationale underlying this decision.

(5) Any No-CPR order should include a statement of the medical condition to justify a No-CPR order.

(6) Any No-CPR order should include a statement about the scope of the order specifying the *management plan* (curative and/or palliative) subsequent to the No-CPR order.

(7) Any No-CPR order should be subject to review on a regular basis and can be rescinded at any time. Any review should be implemented and documented in the patient's progress notes in the manner specified above.

**Table 1: Hospital guidelines for No-CPR order**

## Conclusion

A recent commentator observed, when commenting on the decision-making relationship between patient autonomy, futility and who should receive CPR:

> "CPR is not a harmless technological placebo. CPR may harm the subject, relatives, health-care staff, and society. Each of these four parties has an interest."[35]

Not surprisingly the ethical issues associated with No-CPR remain complex and invite both community and judicial scrutiny in Australia. Furthermore, No-CPR decisions have important and unavoidable implications for hospital resources. The decision to record No-CPR on a patient's chart represents a crucial therapeutic point in the care of the critically ill and should be reached only after reflective and sympathetic discussion with the patient where they so choose, and if they are incompetent to do so, with their family or surrogate and appropriate member(s) of the health care team.

[35] J Sanders, "Who's for CPR?" (1992) 26 *Journal of the Royal College of Physicians of London* 254.