CPR and DNR Orders

Information and recommendations

When to undertake Cardiopulmonary Resuscitation (CPR) given the patient's "best interests" and/or the existence of a Do Not Resuscitate (DNR) order, has been the cause of considerable anxiety for doctors over the years. This advisory is aimed to provide general guidance for doctors faced with a patient potentially requiring CPR. The advisory is based on the NZMA Code of Ethics for the New Zealand Medical Profession[1], and also draws on the New Zealand Medical Journal article "CPR in New Zealand hospitals: an alternative perspective on lawfulness and ways to improve practice"[2]. While the advisory is intended to be helpful, if a doctor is in any doubt s/he should seek advice from senior colleagues and, if indicated, from ethicists and legal authorities.

Default position

In the absence of a DNR order, or previously established clear and clinically based justification for not doing so the default position, ethically and legally, is to start CPR[3].

Ethically the doctor must consider the health and well being of the patient to be the first priority, with an obligation to preserve life wherever possible and justifiable.[4]

Legally, while all procedures generally require consent in order to be lawful, both the common law[5], and the Health and Disability Commission (HDC) Code of Health and Disability Consumers' Rights, provides legal justification for proceeding without consent.

- The common law exception to the requirement for consent is based on the principle of necessity (i.e. acting unlawfully is justified if the resulting good effect materially outweighs the consequences of adhering strictly to the law).
- Under the Code of Rights the exception for requiring consent is where a patient is incompetent and unable to provide consent.[6]
- In addition, CPR may be regarded as a "necessity of life" and doctors may be seen as having a legal duty to provide it unless there is a lawful excuse to not do so.

Clear justification for not providing CPR

Not providing CPR is clearly justified when there is a valid DNR order, or when CPR is not in the best interests of the patient. This determination may be decided medically or by the patient, but can be problematic for the clinician.

While the law and ethics may not always be in alignment, in this case they are. Ethically a review of the NZMA Code of Ethics[7] provides the following guidance.

[1] http://www.nzma.org.nz/sites/all/files/CodeOfEthics.pdf
[2] Moore, M and Grundy, K NZMJ 12 August 2011, Vol 124 No 1340: http://www.nzma.org.nz/journal/124-1340-4811/
[3] Above n2 pp72-73
[4] Above n1
[5] **Common law** (also known as **case law** or **precedent**) is law developed by judges through decisions of courts and similar tribunals rather than through legislative statutes or executive branch action.
[6] Above n2 page 74
[7] Above n1 Principles 1 and 4, and Recommendations 13,18,20 and 23

- It is acceptable ethically to withhold treatment when that treatment would not be to the benefit of the patient's wellbeing.
- The importance of death with dignity should not be underestimated.
- Accordingly a doctor cannot be said to have given due regard to this if they actively provide resuscitation measures in a terminal situation.
- Where there is a disagreement about an appropriate course of action doctors should seek advice.
- Doctors should be aware of statutory provisions. However ethical considerations would take precedent.

Legally, as well as ethically, decisions about a patient's best interests are regarded as incorporating not only medical judgements but also consideration of patients' values and perspectives.

- Case law supports interpreting the "best interests" principle as involving a broad assessment of both medical and non-medical interests. A two stage approach is recommended where firstly, doctors must act in accordance with proper professional standards, and secondly, they must act in the best interests of the patient where "best interests encompasses medical, emotional and all other welfare issues"[8] .
- A lawful excuse not to provide a treatment includes the situation where a medical team or doctor, after due consideration or assessment of the situation and in accordance with a reasonable body of medical opinion, decides that to proceed would not be a significant benefit to the patient in terms of return of function or meaningful extension of life.
- It also should be noted that under law, treatment may be lawfully not offered by providers, based on clinical grounds and on resource limitations (as outlined below).

DNR orders

The time-pressure and the seriousness of the decision to undertake CPR makes it sensible for both clinicians and patients to make decisions in advance where possible. DNR orders are advance directives which authorise the rejection of the default position. The relevant law on patient initiated DNR orders (Advance Directives) can be summarised as follows.

- "A competent patient has the right to refuse treatment (including CPR) but has no corresponding right to receive treatment which is not offered.
- Refusals of treatment (generally) can be contemporaneous or made in advance.
- CPR will be unlawful in the face of a valid advance patient refusal."[9]

The law regarding clinician initiated DNR orders says:

- treatments may be lawfully not offered by providers (individuals and organisations) based on clinical grounds and on resource limitations
- CPR may be lawfully withheld where there is lawful excuse for failing to provide it, such as a valid patient refusal and/or where it is in keeping with good medical practice
- withholding CPR will be unlawful in the absence of such a lawful excuse"[10].

[8] Above n2 page 75
[9] Above n1 page 73
[10] Above n2 page 73

Validity of a DNR order

A patient initiated DNR order is a form of advance directive. Establishing the validity of an advance directive is, however, no easy matter and there is no specific New Zealand case law or clear guidance from case law in other jurisdictions. There are, in legal terms, four requirements for an advance directive to be valid.

a) The individual had to be competent to make the particular decision at the time the decision was made.
b) The decision had to be free from undue influence.
c) The individual had to intend the directive or choice to apply to the present circumstances (this criterion likely incorporates the requirement that the individual was sufficiently informed at the time of making the advance directive).
d) The existence and validity of the advance directive must be clearly established."[11]

Advance directives (including DNR orders) if made by patients in isolation from health professionals are vulnerable to both legal and ethical challenge. For this reason, as well as others, shared decision-making models have distinct advantages.

Recommendations in relation to DNR orders

In regard to both patient initiated and clinician initiated DNR orders, the following is recommended.

- All DNR orders should be discussed with the patient and due weight put on their decision (unless that discussion is not possible at the time a decision must be made with regard to CPR or other resuscitative interventions). Institutions where such decisions may need to be made should have a policy that supports this discussion taking place in a non-acute setting.
- Patients should be advised to review their advance directives periodically as changes in patient condition may alter their wishes with respect to their Advance Directive[12].

Need more help?

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[11] Above n2 page 75
[12] Refer n1 above Principle 2 and Recommendations 21,22 and 24 of the NZMA Code of Ethics