



The use of CPR in New Zealand: is it always lawful?

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Abstract

Since its development in the early 1960s, the use of CPR in the hospital setting has undergone intriguing changes. After initially being used very selectively, at the discretion of the doctor, the use of CPR rapidly expanded to the point that it was promptly begun on all patients having a cardiac arrest in hospital, regardless of the underlying illness. However, it soon became evident that the use of CPR on all patients created problems. In response to this, DNR orders were developed. The standard policy of New Zealand hospitals is now for CPR to be attempted on all patients having a cardiac arrest unless a DNR order is in place. We argue that this approach is not consistent with New Zealand law and that current policies should be amended to bring them into line with the Code of Rights and New Zealand law generally.

The changing use of CPR

By the early 1960s, the medical profession could use cardiopulmonary resuscitation (CPR).¹ Once CPR became available, decisions had to be made about when it should be attempted. A review of the changed patterns of use is instructive.

Initially CPR was used very selectively in a hospital setting: at the discretion of the doctor, and generally on patients with acute illnesses whose cardiac arrests resulted from reversible conditions. This selective use of CPR was linked to the fact that training in its use was fairly restricted, being provided mainly for those doctors (cardiologists, surgeons and anaesthetists) whose patients were most likely to have reversible causes of cardiac arrest.²⁻⁴ For the most part, CPR was used only for hospital patients who had (in Claude Beck's memorable phrase) "hearts too good to die".⁵

In 1965 the introduction to a monograph on CPR stated:

"Resuscitation of the dying patient with irreparable damage to the heart, lungs, brain, or any other vital system of the body has no medical, ethical, or moral justification. The techniques described in this monograph are designed to resuscitate the victims of acute insult, whether it be from drowning, electrical shock, untoward effect of drugs, anaesthetic accident, heart block, acute myocardial infarction or surgery."⁶

Later in the same volume, two of the founders of CPR spelt out principles for its use. The first was as follows:

"1. *The patient must be salvable.* Cardiopulmonary resuscitation is indicated for the patient who, at the time of cardiopulmonary arrest, is not in the terminal stage of an incurable disease. Resuscitative measures on terminal patients will, at best, return them to the dying state. The physician should concentrate on resuscitating patients who were in good health preceding the arrest, and who are likely to resume a normal existence."⁷

With the increased training of health practitioners in CPR, and the development of 'code teams' and 'code protocols' in American hospitals, the use of CPR expanded

rapidly to the point where it was begun promptly on all patients having a cardiac arrest in hospital, regardless of the underlying illness.⁴ One writer states that these changes were instituted “to improve the chances of a response to cardiopulmonary resuscitation, and to ensure good neurologic function in patients who did respond”.⁴ Another suggests that the “ever-present legal threat for failure to resuscitate” was also an important factor.⁸

Problems resulted from the use of CPR on all hospital patients who were having a cardiac arrest.^{4,9} It has been said that “far more often than not CPR transiently restored physiologic stability but prolonged patient suffering”.⁹ By the late 1960s reports of this phenomenon were appearing in the medical literature. They described the agony that many patients experienced from CPR that only prolonged their dying.¹⁰

Sometimes, terminally ill patients were subjected to repeated CPR. Consequently, many practitioners did not commence CPR, or performed less than a full attempt, when they considered CPR inappropriate.⁹

In response, institutions began to develop their own means of indicating that CPR was not to be used on a particular patient if they had a cardiac arrest. As it has been noted:

“At some institutions, these decisions were concealed as purple dots on the medical record or written as cryptic initials in the patient’s chart, whereas at other institutions, they were simply communicated as verbal orders passed on from shift to shift...”⁹

Given the major changes that were occurring in the doctor-patient relationship (including a much greater emphasis on patient autonomy and on patient participation in decision-making³) these developments led to controversy. There was concern about the lack of patient involvement in decisions to withhold CPR, and about the lack of documentation of these decisions. There was felt to be a failure “to provide sufficient rationale and accountability for what did transpire”.⁹ It was in this context that, in the early 1970s, more formal processes began to be introduced.

In 1974, a National Conference on Cardiopulmonary Resuscitation and Emergency Cardiac Care was convened by the National Academy of Sciences and the American Heart Association. Its task was to set standards for basic and advanced cardiac life support. This Conference agreed that decisions not to perform CPR should be formally documented in the medical record, communicated to all staff, and based on patient or “patient surrogate” consent.¹¹ The resulting guidelines were the first of a professional organisation to adopt this approach.

The first hospital policies on do not resuscitate (DNR) orders were reported in the medical literature in 1976.¹²⁻¹⁴ This movement towards explicit DNR orders policies soon spread to other hospitals in the United States.⁹

These changes led to modifications of CPR policies and to a requirement that CPR be attempted on all hospital patients who were having a cardiac arrest, unless a DNR order was in place.^{2-4,8,15} Policies relating to DNR orders evolved over the years. By the late 1980s many hospital policies allowed doctors to make DNR orders for particular patients if, in their judgement, it would be futile to attempt CPR on those patients, once a cardiac arrest occurred.¹⁶ Such policies have been maintained and have spread widely around the World.¹⁵⁻¹⁸

A distinction should be made here, however, between “Not For CPR” orders and “Not for Resuscitation” orders. Resuscitation includes more interventions than CPR and a

person may want to specify what aspects of resuscitation (if any) they would wish to receive in the event of a collapse. Some health professionals and patients/relatives prefer to use the term “allow natural death” (AND) rather than DNR. This positive statement suggests supporting a person through provision of end of life care rather than a withdrawal of care which DNR can imply.¹⁹

Advance directives and medical DNR or AND orders are most useful if they include advice regarding which interventions are considered to be in the patient's interests even if CPR is to be withheld. For instance IV fluids, antibiotics and non-invasive ventilation may still be believed appropriate if there is a reasonable chance of the person regaining their pre-collapse level of functioning. For the same person CPR, invasive ventilation, extracorporeal membrane oxygenation (ECMO), ventricular assist devices and other interventions may be withheld because they would act only as a bridge towards a transplant for which the patient would not consent or be eligible for because of their overall condition.

These distinctions are important since the focus of health staff should be on recognising and responding to early warning signs of deterioration or imminent collapse rather than simply responding to a cardiac arrest. Some of these interventions may be as equally unwanted as CPR by a person who is in the later stages of dying from irreversible processes.

CPR in New Zealand

These changes in the provision of CPR also occurred to New Zealand. Currently, the standard policy of New Zealand hospitals (both public and private) is for CPR to be attempted on all patients having a cardiac arrest unless a DNR order is in place. However, this practice is not consistent with New Zealand law.

CPR and New Zealand Law: advance decisions regarding CPR

By patients

Advance directives in general

Right 7(5) of the Code of Health and Disability Services Consumers' Rights (“the Code”) provides: “Every consumer may use an advance directive in accordance with the common law.” In the context of the Code “advance directive” has a particular broad meaning, as clause 4 of the Code provides that it means any “written or oral directive—(a) By which a consumer makes a choice about a possible future health care procedure; and (b) That is intended to be effective only when he or she is not competent”.

In law there is an important distinction in the legal efficacy of advance directives that request CPR and those which prohibit it.

Requiring CPR

Patients are free to make an advance directive requesting (or even demanding) the provision of CPR if they have a cardiac arrest in the future. However, such an advance directive would not of itself impose a legal obligation to provide CPR whatever the circumstances. Nevertheless, a patient's request to receive CPR would

be an important factor to take into account when deciding whether CPR would be in the patient's best interests, and hence should be provided.

Prohibiting CPR

Right 7(7) of the Code provides that: "Every consumer has the right to refuse services and to withdraw consent to services." This provision is consistent with section 11 of the New Zealand Bill of Rights Act 1990, which states: "Everyone has the right to refuse to undergo any medical treatment." This right would count for little if an advance refusal could be ignored once a patient became incompetent.

In New Zealand law, a competent patient may make the type of advance directive known as an anticipatory refusal of consent. If the patient was adequately informed as well as competent, this anticipatory refusal of consent has effect once the patient becomes incompetent. In the context of CPR, this advance directive is conveniently referred to as a "patient-initiated DNR order".

Where, by a patient-initiated DNR order, a competent and properly informed patient has made an applicable anticipatory refusal of consent to CPR, this will render the provision of CPR unlawful. Its provision in such circumstances would violate the patient's legal right to refuse medical treatment.

This right to refuse CPR must be exercised by the patient: it cannot be delegated to a proxy. New Zealand law does enable a competent adult to grant an enduring power of attorney, whereby (once the adult becomes incompetent) the attorney may give or refuse consent to a wide range of interventions. However, the law imposes some limits. One is that the attorney may not refuse consent to "any standard medical treatment or procedure intended to save that person's life".²⁰ The holder of an enduring power of attorney is therefore precluded from prohibiting CPR on the patient's behalf.

It does not follow that, in the absence of a DNR order, an omission to provide CPR will always be unlawful. On the contrary, it will only be lawful when its provision can reasonably be regarded as being in the patient's best interests.²¹

By providers

In the course of treatment planning, the health professionals in charge of a patient's care may decide that future resuscitation of the patient is not clinically indicated or appropriate. Having made this assessment, a "medically-initiated DNR" order may be put in place as part of the patient's treatment plan.

While medically-initiated DNR orders do not require the patient's consent, many DNR policies require health practitioners to record that the patient has been informed, or that an attempt has been made to do so.

Providing CPR in the face of a medically-initiated DNR order will not, for that reason alone, be unlawful. This is striking contrast to the legal position where a patient has made a valid anticipatory refusal of consent to CPR (i.e. a patient-initiated DNR order).²²

CPR and New Zealand Law: decisions regarding CPR at time of arrest

Sudden cardiac arrest is a medical emergency. At this stage, the patient is unlikely to have the level of competence required for a decision about the provision of CPR. Those providing care have to decide quickly whether to commence CPR.

To provide

In the absence of a patient's valid anticipatory refusal of consent, the provision of CPR is lawful whenever there are reasonable grounds for believing that it is in the patient's best interests.²³

However, it will by no means always be appropriate to provide CPR. The law would support the withholding of CPR in some circumstances, especially where it could be said to be good medical practice to do so.

To withhold

The omission to provide CPR to a patient having a cardiac arrest needs to be examined in the light of the statutory duty to provide "the necessities of life". Section 151 of the Crimes Act 1961 provides that where someone "has charge" of another person, who is unable to withdraw him or herself from such charge, and to provide him or herself with the necessities of life, there "a legal duty to supply that person with the necessities of life". A patient who is having a cardiac arrest in hospital clearly comes within the ambit of section 151, so *prima facie* there is a duty to provide the necessities of life. This would usually include CPR.

However, section 151 goes on to provide an important qualification. The section only imposes criminal responsibility for an omission to provide the necessities of life where this is done "without lawful excuse" (and where the omission caused death or permanent injury to health, or endangered life).

The courts have rarely had to consider what lawful excuses are available to providers who omit to take all possible steps to prolong life. However, New Zealand case law confirms that, where an omission to provide the necessities of life is in accordance with good medical practice, there will be a lawful excuse for it.²⁴

A patient-initiated DNR order would provide a lawful excuse in this context, provided that there was reasonable assurance of the validity of the patient's consent. So too would a medically-initiated DNR order, at least if was made in accordance with what the courts accepted as "good medical practice". But it is not only where there is a DNR order in place that the withholding of CPR may be permitted, or even required, by law.

Both under the Code and apart from the Code, the legal grounds for providing treatment without consent depend upon a judgment that the provision of treatment is in the patient's best interests. Although considerable latitude will be provided for any health practitioner who makes this assessment, often in less than ideal circumstances, the issue of whether further treatment is in the patient's best interests must always be kept to the fore.

Where the omission to provide CPR to a patient having a cardiac arrest is in keeping with "good medical practice", there will be a "lawful excuse" for omitting to provide CPR. A 'medically-initiated DNR order' will be helpful, but not always necessary, for

there to be a “lawful excuse” for omitting to provide CPR on the “good medical practice” grounds.

Where the cardiac arrest is irreversible, there is clearly no duty to provide the necessities of life. Obviously once death has occurred, the question of lawful excuse does not arise. It is the law relating to corpses, rather than living persons, which is then applicable.

Conclusions and recommendations

Advance decisions regarding CPR

‘Patient-initiated DNR orders’ and ‘medically-initiated DNR orders’ should not be equated. Given the different status and legal consequences of DNR orders made by patients and those made by clinicians in the course of treatment planning, a clear distinction should be drawn between them. For a start, we recommend that providers develop different forms: one for where the DNR is patient-initiated (and hence gives effect to a competent patient’s right to refuse treatment); another for where it is initiated by medical practitioners as part of treatment planning. Both patient- and medically-initiated orders should specify whether they refer to CPR alone, or include other interventions which might be required during resuscitation.

Decisions regarding CPR at time of arrest

Health practitioners are not required to provide CPR in situations where it is not clinically indicated or appropriate. Indeed, the provision of CPR without consent, in circumstances where its provision cannot reasonably be regarded as in the patient’s best interests, is unlawful.

We are concerned that current policies do not direct clinicians to consider whether CPR is clinically indicated or appropriate at time of arrest. There is no justification for pressing ahead with CPR where a DNR order has not been made but all involved are agreed that further treatment is not in a patient’s best interests. Hospital policies should therefore be reviewed to ensure that they are in accordance with the criteria provided by New Zealand law.

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20. Protection of Personal and Property Rights Act 1988, ss18(1), 98(4).
21. Re F (Mental Patient: Sterilisation) [1990] 2 AC 1; Rights 7(1), (4) of the Code.
22. However, assuming that there is no one legally competent who is available to give consent on behalf of the patient, it would not be lawful for a clinician to attempt CPR knowing that it was futile, at least in a situation where it was not in the patient's best interests, nor in accordance with good medical practice to do so.
23. See Right 7(4)(a) of the Code.
24. Auckland Area Health Board v A-G [1993] 1 NZLR 235; Shortland v Northland Health Ltd [1998] 1 NZLR 433.