



## **CPR for all? Ethical and medicolegal considerations**

Ross Freebairn

To be maximally effective, cardiopulmonary resuscitation (CPR) should be initiated immediately that it is indicated and continued uninterrupted until spontaneous circulation is restored.

In the acute setting of a cardiac arrest it is impractical for clinicians to resort to reference material to ascertain their legal and ethical obligations in respect to provision of CPR to their patients. Therefore, it is essential that clinicians engaged in acute medicine develop a working understanding of issues relevant to the provision of CPR.

In this issue of *NZMJ* McLennan and colleagues provide a comprehensive review of the legality of both the provision and non-provision of CPR.<sup>1</sup> It should be mandatory reading for any medical practitioner ever likely to be confronted with a cardiac arrest—I guess that covers nearly all of us.

Some aspects of CPR practice are peculiar when compared to other treatments, and therefore are worthy of careful consideration. Firstly, as McLennan and colleagues highlight, current custom and practice in some hospitals is to provide CPR for all unless “consent” or a medical DNR order has been documented.

CPR is possibly unique in medical practice that consent is most commonly sought to not provide a service, in direct contradistinction to every other therapy provided where good medical practice requires that the risk and benefits of treatment is considered and consent obtained before implementation.<sup>2</sup>

While it is widely accepted that initiating emergency actions such as CPR without consent to preserve life is good medical practice, desisting from treatment that will either not influence outcome, or is not in the patients best interest is also good medical practice.<sup>2</sup> In reality, in many settings CPR may be initiated before any reliable information is available.

During CPR further more dependable information often emerges. If this reveals that resuscitation will be unsuccessful or has been refused previously by the patient while competent, then withholding further treatment is entirely appropriate. Indeed, McLennan suggests it would be unlawful to do otherwise, thus raising the possibility that slavish adherence to “CPR for all” may jeopardise staff.

Secondly, CPR practice is peculiar in that either patient consent or a medical order is often preemptively sought to forgo a procedure that is not currently indicated. McLennan's review reminds us that patient advanced directives requesting or prohibiting CPR are supported by Right 7 of the Code of Rights, and may be verbal or written. Ensuring that accurate information is provided to facilitate valid “advanced directive” or “consent not to treat” decisions may not be easy as it first appears.

Questions such as “if your heart stops do you want us to restart it?” or “if your heart stopped, and you could only survive with severe life-limiting brain damage, would

you want CPR?” are typical of those asked of patients in an attempt to document their “CPR status”.

These questions invite an easy-to-document binary response but fail to convey the wide range of potential causes and prognosis that may influence a patient’s choice to reject or accept CPR or a DNR order. If we are serious about patient-initiated Not for CPR, where is the written information package that allows informed choices?

Any informed discussion about CPR should include the likely prognosis. While in hospital, mortality following CPR is typically well above 80%, the public perception is of a much rosier outcome. Such views are consistent with outcomes displayed in the greatest source of lay medical knowledge—the television medical drama.<sup>3</sup>

Unchallenged these unrealistic expectations will influence decisions invalidated the “informed” choice of the patient. An additional confounder is that prognosis may change over time, although not always for the worse. If a patient with septic shock, profound hypotension and anuria (despite very high dose vasopressor support) and with refractory hypoxemia (despite ventilatory support) suffered a cardiac arrest, then CPR would not improve the outcome. However if the arrest did not occur in the acute phase but a week later when intensive support had been successfully weaned, although the prognosis remains grave, then CPR is not necessarily futile. Even meticulously considered medical-initiated “Not for CPR” orders need to be reconsidered as patients progress or diagnosis change.

The third peculiarity is the inconsistent consent processes used. Not-for-CPR discussion are not infrequently held with family without the consent of the individual concerned. Pragmatists argue that should the patient die, the surviving family will be need to be satisfied with the treatment provided, and therefore warrant prior consultation. Planning future treatment with relatives of a competent patient, without the patient’s consent, is ethically unsound as it violates not only the patient’s autonomy but also their right to privacy.

Medically-initiated DNR orders not discussed prospectively with patients can create discord if subsequently divulged, but appear to be legally defensible if they follow good medical practice.<sup>4</sup> Discord may initially arise from erroneous assumptions that CPR is always indicated, but is quite possibly exacerbated by our largely unnecessary negative terminology.

We are not obliged to offer an ineffective antibacterial treatment for a viral illness, to document our “Not-for-Antibiotics” decision nor follow a Not-for-Antibiotics policy? Therefore why is it that we document “Not-for-CPR” orders when CPR is contraindicated, and develop “Not-for-CPR” or “Do Not Resuscitate” policies?

McLennan’s concern—that current policy does not direct clinicians to consider whether CPR is justified—is warranted. A potential solution is to abandon our current in-hospital “CPR for all, unless Not-for-CPR” policies to develop more informed definitive “For CPR” policy. Then an active request or medical order for CPR becomes the norm for mandated CPR treatment at a cardiac arrest.

If consistently applied at admission, all potentially resuscitatable patients would be prospectively identified. To achieve this admitting clinicians would need to be better informed about the likely prognosis from CPR in a wide variety of circumstances.<sup>5</sup>

Whatever changes we do or do not make, all clinicians need to be cognisant of their obligations outlined in the “The use of CPR in New Zealand” article.

**Competing interests:** None.

**Author information:** Ross Freebairn, Clinical Director, Acute Services, Hawke’s Bay Hospital, Hastings

**Correspondence:** Dr Ross Freebairn, Intensive Care, Hawke’s Bay Hospital, Omaha Road, Hastings, New Zealand. Fax: +64 (0)6 8781365 ; email: [ross.freebairn@xtra.co.nz](mailto:ross.freebairn@xtra.co.nz)

### **References:**

1. McLennan S, Paterson R, Skegg PDG, Aickin R. The use of CPR in New Zealand: is it always lawful? N Z Med J. 2011;124(1328). <http://www.nzma.org.nz/journal/124-1328/4511>
2. St George I (editor). Cole’s Medical Practice in New Zealand,. [www.mcnz.org.nz/portals/0/publications/Coles/Cole's%202009.pdf](http://www.mcnz.org.nz/portals/0/publications/Coles/Cole's%202009.pdf)
3. Diem SJ, Lantos JD, Tulsy JA. Cardiopulmonary resuscitation on television. Miracles and misinformation. N Engl J Med 1996, Jun 13;334(24):1578-82
4. Peach J. Shock decision by Palmerston North doctor. TV3; 29 Oct 2010. <http://www.3news.co.nz/Shock-decision-by-Palmerston-North-doctor/tabid/423/articleID/183794/Default.aspx>
5. Sandroni C, Nolan J, Cavallaro F, Antonelli M. In-Hospital cardiac arrest: Incidence, prognosis and possible measures to improve survival. Intensive Care Med 2007;Feb;33(2):237-45.