LEADING ARTICLE

THE DO-NOT-RESUSCITATE ORDER

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SINGAPORE MED J 1995; Vol 36: 258-259

Unresolved issue

The medical profession has had experience of cardiopulmonary resuscitation (CPR) for some 30 years and of "Do-not-resuscitate" (DNR) orders for 15 years[1]. It might be expected that the choice of when to and when not to resuscitate would have been reasonably well clarified over these years. This has not yet been resolved.

Futility of CPR in some situations

Nevertheless, progress has been made. The futility of CPR is recognised under certain situations. An editorial commentary in 1983 in the Lancet cautioned against the persistent diagnostic and therapeutic endeavour associated with high-technology medicine in dying patients[2]. An editorial in 1985 in Anaesthesia stated that there are certain groups of patients who should not be resuscitated[3].

DNR order in recent years

DNR orders have been widely practised in the West. For example, Steward et al[4] reported that 30% of acute admissions in a general hospital in the United Kingdom had DNR orders. In America, DNR policies are now in use in over half of US hospitals and DNR orders typically required patient or family consent and a written record[5]. A study of the use of DNR orders in Dutch hospitals as part of a nationwide study on medical decisions concerning the end of life by van Delden et al[6] showed that DNR decisions were made in 6 percent of all admissions, and 61 percent of all in-hospital deaths were preceded by a DNR decision.

There is however not much involvement of patients in the DNR decision. In the Dutch study[6] only 32 percent of the cases who were competent to make a decision had been involved in the DNR decision. More patient involvement would have been desirable. This will require more dialogue between the attending doctors, the patient and family members.

Several studies of patients' attitudes to CPR have been conducted in the USA, and there is evidence that senile dementia more than any other condition has a bearing on patients' wishes for future DNR status. The Scottish study by Robertson[1] showed that out of 322 outpatient subjects, 97 percent would opt for CPR in their current state of health. In the hypothetical circumstances of having advanced senile dementia, 75% preferred not to have CPR. There were no significant correlations between the responses and sex or age. Of 270 patients asked verbally if they found the questions disturbing, none said they did[1]. The author concluded that this should encourage further investigation of patients' opinions in CPR in a broader range of conditions and greater use of DNR orders.

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Guidelines on the DNR order

Despite the widespread use of DNR orders in many hospitals in the West, there has been no formal policy until recent years. Several guidelines on the DNR order have since been published. Thus, in 1992, guidelines were issued by the Ethics and Nursing Committee of the Royal College of Nursing, the British Geriatrics Society, and the Royal College of Radiologists[7].

In 1993, the Royal College of Physicians of London discussed the DNR order in the adult in its Journal and this was followed by a publication of a guideline in the April issue of its Journal[8]. In it, it mentioned that a detailed listing of specific medical conditions for which DNR orders would be particularly appropriate should be avoided as far as possible in view of the many exceptions that occur in clinical practice. Most of the conditions are likely to come from within the following main categories of disease: terminal metastatic disease, severe cardiorespiratory failure, advanced cardiovascular disease, cerebrovascular disorders with severe stroke, and dementia, including patients with advanced Alzheimer's disease. In making DNR decisions in the elderly, the College guideline reiterated the point that it is important not to miss an underlying depression, treatment of which could change the patient's attitude to living.

The College's five-point guideline covered the circumstances under which the decision making will be made. Its first point said that in most circumstances making a DNR decision should depend upon an assessment by the consultant or senior registrar in charge with other members of the medical and nursing staff who are directly involved in the case of the particular patient. If there is any doubt within that group as to the rightness of such a decision then it is the responsibility of the consultant or senior registrar to seek further medical opinion at senior level, and if there is any remaining disagreement the matter will need to be referred to the clinical or unit director. Sapthis[9] in a letter to the editor of the College Journal expressed the view that nothing will be gained by referring to the clinical or unit director as the next decision maker. He felt that if there is doubt at the senior level, opinion should be sought from someone with special expertise. The second point of the guideline dealt with decision making by junior staff: where a junior staff needs to undertake the decision on the DNR order as for example, within the first 24 hours of an emergency admission for nursing care of a patient with terminal metastatic disease or a severe stroke, that decision needs to be reviewed with senior staff at the first opportunity. The remaining points covered the need for a cognisance of the patient and family members' views with respect to resuscitation; the need of eliciting the views of the relatives in a patient too ill to express a view and

that view is not known; and the need to record the categorical DNR order together with reasons for that decision and a periodic review of the order.

A DNR policy for Singapore

In this issue of the Journal, Sahadevan et al have made a suggestion that Singapore develops a guideline on DNR orders[10]. They have proposed a ten-point guideline and discussed their rationale for the proposed guideline. Three of their points in their guideline deserve comment.

The family's informed knowledge and wishes

Point 6 of the proposed Singapore guideline states that consent from the patient and/or family members is not necessary for the DNR decision but rather the discussion should inform them of the medical realities and attempt to persuade them of the reasonableness of the DNR order. *Information, medical realities and persuasion* are key words in the vitally important communciation process. The authors go on to say that should there be strong or persistent disagreement between the doctor and the patient or family in the decision on DNR, it may not be wise to go ahead with the implementation of the DNR decision even when medical futility is its underlying basis; rather the DNR decision should be postponed. This is wise counsel.

Poor quality of life despite successful CPR

Point 7 of the proposed Singapore guideline points out that when it is thought that the patient may have a poor quality of life and that the CPR, though probably successful, may not be meaningful, the issue of DNR should be discussed with family members. Examples of such scenarios, as has been described, are multiple strokes resulting in a vegetative state, profound dementia and chronic debilitating illness with a poor functional state. This is a quality of life decision and family members must again see the reasonableness of the DNR order before this is implemented.

Care must continue

Point 8 is important. It is important to recognise that once a DNR order has been given the rest of the patient's management should not be stopped or reduced. Therapeutic and supportive care is an independent matter to be addressed by doctors and nurses based on the clinical problems of the patient. DNR is not active or passive euthanasia. DNR does not seek to help patient to die. It only holds in abeyance the initiation of CPR because it is clear it is futile to do so.

CONCLUSION

Sahadevan et al have put up a good case for a guideline on DNR orders for Singapore. Their views deserve support. They have included in their guideline, the need that each case should be carefully considered on its own merits. They have also pointed out the importance of sharing the doctor's view of the futility for CPR with the patient and his family. Most importantly, they have made the point that patient must continue to be cared for expertly after the DNR order.

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