

New Zealand Resuscitation Council Consultation Meeting
Ellerslie Convention Centre, 6 April 2009

Introductory remarks

Thank you for the invitation to open your meeting. It's great to see the work being done to improve the quality of resuscitation provided in New Zealand. I especially like your meeting theme, "Closing the Loop". So often at HDC cases we see situations where no one closes the loop — with the patient and family, but also between primary and secondary care, and between teams within hospital.

In my introductory remarks this morning, I want to touch on the topic of DNR. We receive very few complaints directly relating to resuscitation, but we are often asked to comment on DNR or "Not for CPR" policies. These policies have the recurring element of CPR being the required default position for all patients having a cardiac arrest.

Indeed, it appears that the standard policy of New Zealand hospitals (public and private) and residential care facilities is for CPR to be attempted on *all* patients having a cardiac arrest unless a DNR order is in place. There are two types of DNR orders, 'patient initiated DNR orders' and 'medically initiated DNR orders'.

However, this approach may not be good medical or legal practice. A few features of current practice stand out:

- First, the current outcomes of CPR. One wonders how often CPR is used, to borrow T.S. Eliot's words, "not for the good that it will do, but that nothing may be left undone on the margin of the impossible".
- Second, health practitioners' views. A 2006 study at Dunedin Hospital (unpublished) found that many health practitioners feel required to perform CPR in inappropriate and futile situations. Sample responses included: "*CPR is usually done in futile situations, as we have to do it*", "*We are doing CPR too often on people who shouldn't be resuscitated, should be doing less resuscitations*".
- Finally, and effectively a by-product of these two situations is the 'slow code' phenomenon, involving delayed or token efforts to provide CPR. Slow codes tend to occur where there is no DNR order in place, and it is thought that CPR must be performed, even though the clinicians see attempting CPR on the patient having the cardiac arrest as clearly inappropriate and futile.

One of my functions as Commissioner, under section 14(1)(i) of the Health and Disability Commissioner Act 1994, is "[t]o make suggestions to any person in

relation to any matter that concerns the need for, or the desirability of, action by that person in the interests of the rights of health consumers or disability services consumers or both.”

I would like to make some suggestions this morning concerning the desirability of amending current CPR/DNR policies to bring them more into line with the rights found in the Code, and New Zealand law in general. I think this is an area where law and ethics support some changes to current medical practice.

1. Advance decisions regarding CPR

By consumers

Advance directives in general

Right 7(5) provides that: “Every consumer may use an advance directive in accordance with the common law.”

An advance directive records a consumer’s choice about future care procedures, and only becomes effective when the consumer is not competent to make an informed choice and give informed consent.

Requesting CPR

A consumer may make an advance directive requesting the provision of CPR if they have a cardiac arrest in the future. However, this does not require health practitioners to provide CPR. A consumer cannot *require* the provision of a particular treatment.

However, if a consumer has expressed a preference to receive CPR, it will be important for the provider to consider when they are deciding whether it is appropriate to provide CPR.

Declining CPR

Right 7(7) provides that: “Every consumer has the right to refuse services and to withdraw consent to services.” Of course, this right would be far less significant if its effect lapsed once a person became incompetent. However, a competent consumer may make an anticipatory refusal of consent to a treatment in an advance directive. This is a patient initiated DNR order.

Where a competent consumer has made an anticipatory refusal of consent to CPR, in a clear advance directive, this will render the provision of CPR unlawful, as its provision in such circumstances would violate the consumer’s right to refuse medical treatment. A DNR order (at least, a patient initiated DNR order) can be a form of advance directive. (As an aside, it is important that DNR directives are not framed as

instructions for clinicians to remain completely “hands off”, as this could prevent relief of distress and provision of comfort cares — for the benefit of the patient and family.

However, neither the clinicians in charge of a patient’s care, nor the patient’s legal representative (EPOA), can make an advance directive declining CPR, since EPOAs are not entitled to refuse consent to lifesaving treatment, under section 18(1)(a) of the PPPR Act 1988.

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 medical initiated DNR order may be put in place as part of the patient’s future treatment plan.

While medically initiated DNR orders do not require the patient’s consent to be put in place, many CPR/DNR policies require health practitioners to attempt to inform patients of this situation and record that this attempt has been made.

The provision of CPR circumstances in which a medically initiated DNR order has been put in place is not, however, unlawful, in contrast to the position where a patient has given a valid anticipatory refusal of consent to CPR.

Recommendation

It is a mistake to treat ‘patient initiated DNR order’ and ‘medically initiated DNR orders’ as the same, as current CPR/DNR policies in New Zealand do by requiring CPR to be attempted in every cardiac arrest unless a DNR order (patient initiated *or* medically initiated) is in place.

On 6 March 2009, I suggested to Hutt Valley DHB (06/12314) that:

“In view of the distinction between treatment planning by clinicians and non-resuscitation advance directives made by consumers, it would be helpful to separate the discussion of these two types of decisions, rather than referring to them collectively as ‘DNAR decisions’ throughout the policy.

To further clarify the distinction between the different types of resuscitation decisions, I suggest Hutt Valley DHB develops different standard forms for advance directives by consumers regarding resuscitation, and non-resuscitation orders put in place by clinicians as part of a patient’s treatment plan.”

2. Decisions regarding CPR at time of arrest

Sudden cardiac arrest is a medical emergency. Those providing care at this time need to make a prompt decision about resuscitation.

To provide

In the absence of a valid anticipatory refusal of consent to CPR by the patient, the provision of CPR at the time of cardiac arrest will be *lawful* as emergency treatment intended to preserve life.

However, it may not necessarily be clinically appropriate. Ethics and the law may support the withholding of CPR in some circumstances.

To withhold

The omission to provide CPR to a patient having a cardiac arrest needs to be seen in the context of the oft cited section 151 of the Crimes Act 1961, and the duty to provide “the necessaries of life”.

Where a person “has charge” of another person, who is unable to withdraw him or herself from such charge, and to provide him or herself with the necessaries of life, section 151 imposes “a legal duty to supply that person with the necessaries of life” upon the person in charge. A patient having a cardiac arrest clearly amounts to the kind of helpless person section 151 envisages, and thus there would be a duty on the responsible health practitioner to provide the necessaries of life.

The “necessaries of life” include anything necessary to sustain life or health, and on one view, where life is (or would be) prolonged by medical technology, that technology is a necessary of life for that person.

However, section 151 imposes criminal responsibility for an omission to provide the necessaries of life only where there is *no lawful excuse* for the omission, and where the omission caused death or permanent injury to health, or it endangered life.

While the courts have rarely had to consider what lawful excuses are available to providers who omit to take all possible steps to prolong life, the cases of *Auckland Area Health Board v A-G* (1993) and *Shortland v Northland Health Ltd* (1998), confirmed that where such an omission is in keeping with “good medical practice”, those responsible have a “lawful excuse” for non-compliance with the prima facie duty to prolong life.

Thus, 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 in circumstances in which there would otherwise be a duty to provide it under section 151. It is important to note that a ‘medically-initiated DNR order’ is not *necessary* for there to be a “lawful excuse” for omitting to provide CPR on “good medical practice” grounds.

Recommendations

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 where it is not in the best interests of the patient may incur liability.

The decision to provide or not provide CPR to a consumer having a cardiac arrest, in the absence of a valid anticipatory refusal of consent to CPR by that patient, needs to be a contextual consideration of that patient’s best interests (informed by what is known about the patient’s views). This must be done on a case-by-case basis.

As I also wrote in my letter to Hutt Valley DHB:

“For example, in paragraph 6, under the heading of “The Default Decision”, the policy states:

‘Where no explicit advance decision has been made prior to a patient suffering a respiratory or cardiac arrest, and the wishes of the patient are unknown and cannot be ascertained, then health professionals will commence CPR.’

... I am concerned about the expression of this default decision because it does not direct clinicians to consider whether CPR is clinically indicated. Accordingly, I suggest that Hutt Valley DHB adds ‘if it is clinically indicated’ to the end of the above sentence in the policy.”

3. Discussions surrounding CPR/DNR

I would like to conclude with some brief comments in relation to the discussion of CPR and medically-initiated DNR orders with consumers.

As noted above, while medically-initiated DNR orders do not require the patient’s consent to be put in place, many DNR or not for CPR policies require health practitioners to attempt to inform patients of this situation and record that this attempt has been made. However, some providers do not inform patients that they have put in place a medically initiated DNR order, a practice which patients and families may find concerning.

In the case of Folole Muliaga, a decision was made by her doctor that she was not for resuscitation, but was never discussed with Mrs Muliaga or her family. Coroner Matenga felt that it was “concerning that such an important decision was made and not communicated to Mr Muliaga [or] to her family” (Inquest findings, 19 September 2008).

I agree that patients should generally be informed that the clinicians in charge of their care have decided that CPR will not be preformed if they are to have a cardiac arrest. However, I consider it more important that patients are told about things as their future prognosis and the direction of their healthcare, and are given the opportunity to discuss these matters with their health practitioner. While the issue of CPR *may* arise in such discussions, it may not.

Here I draw on the work of Grant Gillett and Stuart McLennan.

It is somewhat concerning that, while surgical patients are usually spoken to about their problem and the proposed treatment within 72 hours of their admission — because that is necessary in the context of informed consent — the same does not go for medical patients. Often they go through a number of changes of care without such a frank and informative discussion, so they neither understand the tests and interventions happening to them, nor get the chance to contribute to the decision-making process that is occurring within the healthcare team.

Communication is essential and should be timely so that the patient understands the evolving course of treatment and the information to be expected from the tests they are undergoing. Their participation in and consent to the unfolding regimen of care can then be based on an intelligent and informed grasp of what is happening to them.

Doctors, nurses and families (where the family’s involvement is acceptable to the patient) need to work together to make decisions (whether about the limitation of treatment, not initiating CPR, or withdrawal of life-sustaining treatment). They should be part of end-of-life conversations that should be a routine aspect of health care delivery. When the patient has an opportunity to talk about their illness, their treatment, and their values, discussion about how we die, often using the words “allow a natural death”, are much more comfortable for patient and doctor, rather than baldly asking “Do you want to be resuscitated?”

When decisions are made in the light of a realistic appraisal of the patient’s situation, with tact and consideration, the emphasis can shift to what is fitting in the context of the patient’s life and present illness.

Such an approach meets the needs of patients and families – and of health professionals, who often experience moral distress when continuing a course of invasive care that has never been properly discussed with the patient and family. It can also reduce the risk of unanswered questions, unhappiness and complaint after the patient dies. A Healthcare Commission report in 2007 analysed 16,000 complaints from 2004 to 2006. 54% of complaints about hospitals were about care surrounding a death.

There are signs of improvements in quality of care for people dying in hospital — notably in the study by Stuart McLennan and colleagues at Dunedin Hospital in 2003. End-of-life discussions took place in 82% of cases; 74% of those who died had a DNR order in place, and a remarkable 96% of those in whom pain status was documented (70%) were pain free. So communication and planning does seem to be improving.

I wish you well for your important deliberations over the next two days.

Ron Paterson
Health and Disability Commissioner