Decisions relating to cardiopulmonary resuscitation

A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing

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Royal College of Nursing

Resuscitation Council (UK)

BMA

Introduction

Health professionals are aware that decisions about attempting cardiopulmonary resuscitation (CPR) raise very sensitive and potentially distressing issues for patients and people emotionally close to them. Some health professionals do not find it easy to discuss CPR with their patients, but this must not prevent discussion, either to inform patients of a decision or involve patients in the decision-making process, where appropriate. The guidelines that follow identify the key ethical and legal issues that should inform all CPR decisions. These basic principles are the same for all patients, in all settings, but differences in clinical and personal circumstances make it essential that all CPR decisions are made on an individual basis. The guidelines provide a framework to support decisions relating to CPR and communicating them effectively.

These guidelines do not address all the complex clinical considerations that healthcare teams face. The guidelines do not distinguish between basic and advanced CPR because the underlying ethical and legal principles that govern decision-making are the same. The guidelines provide the general principles that allow local CPR policies to be tailored to local circumstances. Local policies may also contain more detailed guidance than can be provided here; this may include specific information about the allocation of individual responsibilities.

Professional nursing and medical organisations will be able to advise on the application of a CPR policy to specific areas of practice. Details of some additional published guidance are given at the end of this document.

This document will be reviewed jointly by the British Medical Association, Resuscitation Council (UK) and Royal College of Nursing as policy and legislation develops. For example, the Mental Capacity Act 2005 (England and Wales) did not come into full force until the 1 October 2007 and the practical provisions for its implementation will only be clarified over time. The most up-to-date version of this guidance will be available on the organisations' websites listed below.

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Main messages

This part of the guidance is not designed to be read in isolation from the rest of the document. Given the very serious nature of the decisions being made, we would urge all readers to take the time to consider the whole of the document. These are intended to highlight some of the main points arising from the guidance, as an aide-mémoire.

All establishments that face decisions about attempting cardiopulmonary resuscitation (CPR) including hospitals, general practices, care homes and ambulance services, should have a policy about CPR attempts. These policies must be readily available to and understood by all relevant staff.[1]

- Decisions about CPR must be made on the basis of an *individual* assessment of each patient's case.
- Advance care planning, including making decisions about CPR, is an important part of good clinical care for those at risk of cardiorespiratory arrest.
- Communication and the provision of information are essential parts of good quality care.
- It is not necessary to initiate discussion about CPR with a patient if there is no reason to believe that the patient is likely to suffer a cardiorespiratory arrest.
- Where no explicit decision has been made in advance there should be an initial presumption in favour of CPR.
- If CPR would not re-start the heart and breathing, it should not be attempted.
- Where the expected benefit of attempted CPR may be outweighed by the burdens, the patient's informed views are of paramount importance. If the patient lacks capacity those close to the patient should be involved in discussions to explore the patient's wishes, feelings, beliefs and values.
- If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision refusing CPR, this should be respected.
- A Do Not Attempt Resuscitation (DNAR) decision does not override clinical judgement in the unlikely event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged.
- DNAR decisions apply only to CPR and not to any other aspects of treatment.

Contents

1. Introduction . . . 6
2. Advance care planning . . . 6
3. Non-discrimination . . . 7
4. Human Rights Act 1998 . . . 7
5. Presumption in favour of CPR when there is no DNAR decision . . . 7
6. Clinical decisions not to attempt CPR . . . 8
   - 6.1 Communicating DNAR decisions to patients . . . 9
   - 6.2 Requests for CPR in situations where it will not be successful . . . 10
7. Decisions about CPR that are based on benefits and burdens . . . 10
   - 7.1 Communication and discussion with patients or those close to patients who lack capacity . . . 12
   - 7.2 Requests for CPR where the burdens may outweigh the benefits . . . 13
8. Refusals of CPR by adults with capacity . . . 13
   - 8.1 Advance decisions refusing CPR . . . 14
   - 8.2 Assessing validity and applicability . . . 14
9. Adults who lack capacity . . . 15
   - 9.1 Patients with a welfare attorney or court-appointed deputy or guardian . . . 15
   - 9.2 Adults who lack capacity, have neither an attorney nor an advance decision but do have family or friends . . . 16
   - 9.3 Adults who lack capacity and have no family, friends or other advocate whom it is appropriate to consult . . . 17
10. Children and young people . . . 17
11. Confidentiality . . . 18
12. Information for patients . . . 18
13. Responsibility for decision-making . . . 19
14. Recording decisions . . . 19
15. Communicating decisions to other health care providers . . . 19
16. Review . . . 20
17. Standards, audit and training . . . 21

Decision-making framework . . . 22

Other published guidance . . . 23

References . . . 24

1. Introduction

The primary goal of healthcare is to benefit patients, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, or ceases to benefit the patient, or if an adult patient with capacity has refused treatment, that treatment is no longer justified.

Prolonging a patient's life usually provides a health benefit to that patient. Nevertheless, it is not appropriate to prolong life at all costs with no regard to its quality or to the potential burdens of treatment for the patient. The decision to use any treatment should be based on the balance of burdens, risks and benefits to the individual receiving the treatment, and that principle applies as much to cardiopulmonary resuscitation (CPR) as to any other treatment.

CPR is undertaken in an attempt to restore breathing (sometimes with support) and spontaneous circulation in a patient in cardiac and/or respiratory arrest. CPR is a relatively invasive medical therapy and usually includes chest compressions, attempted defibrillation with electric shocks, injection of drugs and ventilation of the lungs. In some cases spontaneous cardiac function may be restored with prompt use of an electric shock alone.

The survival rate after cardiorespiratory arrest and CPR is relatively low. After CPR for cardiorespiratory arrest that occurs in hospital, the chances of surviving to hospital discharge are at best about 15-20%.[2] Where cardiac arrest occurs out of hospital, the survival rate is lower, at best 5-10%.[3] The probability of success depends on factors including the cause of the arrest, how soon after the arrest CPR is started, and the equipment and staff available to deliver it. Attempting CPR carries a risk of significant adverse effects such as rib or sternal fractures, hepatic or splenic rupture, or prolonged treatment in an intensive care unit (ICU), possibly including prolonged artificial ventilation.

In the immediate post-CPR period most patients require at least a brief period of observation and treatment in an ICU or a coronary care unit (CCU) or both.[4] Some patients will require treatments such as artificial ventilation, renal dialysis or haemofiltration, and circulatory support with inotropic drugs and/or an intra-aortic balloon pump. It is not uncommon for difficult decisions about CPR to arise in respect of patients for whom it may be possible to re-start the heart after cardiac arrest but for who admission to an ICU for continued organ support would be clinically inappropriate because they would be unlikely to survive their admission to the ICU.

There is also a risk that the patient will be left with brain damage and resulting disability, especially if there is delay between cardiorespiratory arrest and the initiation of the CPR. Some CPR attempts may be traumatic, meaning that death occurs in a manner that the patient and people close to the patient would not have wished.

2. Advance care planning

Healthcare professionals have an important role in helping patients to participate in making appropriate plans for their future care in a sensitive but realistic manner, making clear whether or not attempted CPR could be successful. Helping patients to reach a clear decision about their wishes in respect of CPR should be regarded as a marker of good practice in any healthcare setting and the use of advance care planning should be subject to clinical audit.

For many patients receiving care in hospital or in the community, the likelihood of cardiorespiratory arrest is small and no clinical decision is made in advance of such an event. If cardiorespiratory arrest does occur unexpectedly, CPR should be attempted in accordance with the advice in these guidelines (see section 5). There is no ethical or legal requirement to discuss every possible eventuality with all patients and if the risk of cardiorespiratory arrest is considered very low it is not necessary to initiate discussion about CPR with the patient, or with those close to patients who lack capacity.

In some cases there is an identifiable risk of cardiac or respiratory arrest, either because of an underlying incurable condition (such as cancer), because of the patient's medical history (such as recent myocardial infarction or stroke), or current clinical condition (such as severe sepsis). If there is a risk of cardiac or respiratory arrest it is desirable to make decisions about CPR in advance whenever possible. There should be a full clinical assessment of the chances of a successful outcome.

Advance care planning should be undertaken only by those who have the necessary training and experience. Ensuring that discussion takes place about CPR and a decision is made in advance, where possible, is preferable to making decisions in a crisis when there may be insufficient time to gather and consider all of the relevant information relating to the patient's wishes and clinical condition. Making such decisions in a crisis can be more stressful for the staff and those close to the patient.

3. Non-discrimination

Any CPR decision must be tailored to the individual circumstances of the patient. It must not be assumed that the same decision will be appropriate for all patients with a particular condition. Decisions must not be made on the basis of assumptions based solely on factors such as the patient's age, disability, or on a professional's subjective view of a patient's quality of life. Blanket policies that deny CPR to groups of patients, for example to all patients in a hospice or nursing home or to patients above a certain age, are considered unethical and are probably unlawful.

When assessing whether attempting CPR may benefit the patient, decision-makers must not be unduly influenced by any of their own pre-existing (negative or positive) views about living with a particular condition or disability. The key issue to consider is not the decision-maker's view of the patient's disability or level of recovery that can reasonably be expected following CPR but an objective assessment of what is in the best interests of the patient, taking account of all relevant factors, particularly the patient's own views.

4. Human Rights Act 1998

Policies and individual decisions about CPR must comply with the Human Rights Act 1998. This Act incorporates the bulk of the rights set out in the European Convention on Human Rights into UK law. In order to meet their obligations under the Act, health professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention. Provisions particularly relevant to decisions about attempting CPR include the right to life (Article 2), to be free from inhuman or degrading treatment (Article 3), to respect for privacy and family life (Article 8), to freedom of expression, which includes the right to hold opinions and to receive information (Article 10) and to be free from discriminatory practice in respect of these rights (Article 14). The spirit of the Act, which aims to promote human dignity and transparent decision making, is reflected in these ethical guidelines.

5. Presumption in favour of CPR when there is no DNAR decision

If no explicit decision has been made in advance about CPR and the express wishes of the patient are unknown and cannot be ascertained, there should be a presumption that health professionals will make all reasonable efforts to attempt to revive the patient in the event of cardiac or respiratory arrest. In such emergencies there will rarely be time to make a proper assessment of the patient's condition and the likely outcome of CPR and so attempting CPR will usually be appropriate. Medical and nursing colleagues should support anyone attempting CPR in such circumstances.

There may be some situations in which CPR is commenced on this basis, but during attempted resuscitation further information comes to light that makes continued CPR inappropriate. That information may consist of a DNAR order or a valid and applicable advance decision refusing CPR in the current circumstances, or may consist of clinical information indicating that CPR will not be successful. In such circumstances, continued attempted resuscitation would be inappropriate.

There will be some patients for whom attempting CPR is clearly inappropriate; for example a patient in the final stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal DNAR decision has been made. In such circumstances, healthcare workers who make a considered decision not to commence CPR should be supported by their senior colleagues and employers.

6. Clinical decisions not to attempt CPR

In some cases, the decision not to attempt CPR is a straightforward clinical decision. If the clinical team believes that CPR will not re-start the heart and maintain breathing, it should not be offered or attempted. CPR (which can cause harm in some situations) should not be attempted if it will not be successful. However, the patient's individual circumstances and the most up-to-date guidance must be considered carefully before such a decision is made. The responsibility for making the decision rests with the most senior clinician currently in charge of the patient's care, although they may delegate the task to another person who is competent to carry it out. Wherever possible, a decision should be agreed with the whole healthcare team. The overall clinical responsibility for decisions about CPR, including DNAR decisions, rests with the most senior clinician in charge of the patient's care as defined by local policy. The most senior clinician could be a consultant, GP or suitably experienced nurse. In certain settings an experienced nurse may be the senior clinical decision maker. Examples include nurse consultants or senior clinical nurses working in palliative care. If there is genuine doubt or disagreement about whether CPR would be clinically appropriate a further senior clinical opinion should be sought.

When a patient is in the final stages of an incurable illness and death is expected within a few days, CPR is very unlikely to be clinically successful. In some cases it may prolong or increase suffering and subject the patient to traumatic and undignified death. In these circumstances, most patients want a natural death without unnecessary interventions that most consider to be undignified. Earlier discussions with patients about their general care and treatment aims may have addressed this issue. For example, in the context of palliative care, where patients are known to have an incurable illness, discussion and explanation about the realities of attempting CPR may occur in advance of the last few days of life. The Liverpool Care of The Dying Pathway (LCP)[5] is currently being implemented throughout the UK. The LCP provides a comprehensive template of appropriate evidence-based multidisciplinary care for the last days of life. Goal 3 of the initial assessment of the LCP specifically prompts clinicians to consider and document the patient's CPR status.

Uncommonly, some patients for whom a DNAR decision has been established may develop cardiac or respiratory arrest from a readily reversible cause such as choking, induction of anaesthesia, anaphylaxis or blocked tracheostomy tube. In such situations CPR would be appropriate, while the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances.

In addition to readily reversible causes, it may be appropriate to temporarily suspend a decision not to attempt CPR during some procedures if the procedure itself could precipitate a cardiopulmonary arrest – for example, cardiac catheterisation, pacemaker insertion, or surgical operations.[6] General or regional anaesthesia may cause cardiovascular or respiratory instability that requires supportive treatment. Many routine interventions used during anaesthesia (for example tracheal intubation, mechanical ventilation or injection of vasoactive drugs) may be regarded as resuscitative measures. Under these circumstances, where there are often easily reversible causes of a cardiorespiratory arrest, survival rates are much higher than those following other causes of in-hospital cardiac arrest. DNAR decisions should be reviewed in advance of the procedure. Ideally this should be discussed with the patient, or their representative if they lack capacity, as part of the consent process. Some patients may wish a DNAR decision to remain valid despite the increased risk of a cardiorespiratory arrest and the presence of potentially reversible causes; others will request that the DNAR decision is suspended temporarily. The time at which the DNAR decision is reinstated should also be discussed and agreed.

If a patient wishes an advanced decision refusing CPR to remain valid during a procedure or treatment that increases the risk of or induces cardiorespiratory arrest (e.g. cardiac surgery), this may significantly increase the risks of the procedure or treatment. If a clinician believes that the procedure or treatment would not be successful with the DNAR order still in place, it would be reasonable not to proceed.

6.1 Communicating DNAR decisions to patients

When a clinical decision is made that CPR should not be attempted, because it will not be successful, and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate discussion with the patient to explore their wishes regarding CPR.

Careful consideration should be given as to whether or not to inform the patient of the decision. Although patients should be helped to understand the severity of their condition, whether they should be informed explicitly of a clinical decision not to attempt CPR will depend on the individual circumstances. In most cases a patient should be informed, but for some patients, for example those who know that they are approaching the end of their life, information about interventions that would not be clinically successful will be unnecessarily burdensome and of little or no value. Others indicate by their actions and involvement in decision-making that they want detailed information about their care and want to be fully involved in planning for the end of their life. Therefore an assessment should be made of how much information the individual patient (or, if the patient lacks capacity, those close to them) wants to know. The decision must be the one that is right for the patient and information should never be withheld because conveying it is difficult or uncomfortable for the healthcare team. In considering this clinicians need to take account of the fact that patients are legally entitled to see and have a copy of their health records,[7] so it may be preferable for them to be informed of the existence of a DNAR decision and have it explained to them rather than for them to find it by chance. It may be distressing to them to find out by chance that a DNAR decision has been made without them being involved in the decision or being informed of it.

If the patient lacks capacity and has appointed a welfare attorney whose authority extends to making these clinical decisions, or if a court has appointed a deputy or guardian with similar authority to act on the individual's behalf, this person should be informed of the decision and the reason for it. If a second opinion is requested, this should be arranged, whenever possible.

Clinicians discussing or communicating such decisions should:

- offer patients as much information as they want
- provide information in a manner and format which patients can understand; this may include the need for an interpreter
- answer questions as honestly as possible
- explain the aims of treatment.

Clinicians should document the reason why a patient has not been informed of a DNAR order if the decision is made not to inform the patient. Clinicians may be asked to justify their decision.

A decision not to attempt CPR applies only to CPR. It must be made clear to patients, people close to patients and members of the healthcare team that it does not apply to any other aspect of treatment and that all other treatment and care that are appropriate for the patient will continue. To avoid confusion, the phrase 'do not attempt cardiopulmonary resuscitation' should be used to record DNAR decisions. The BMA issues guidance on decisions to withdraw or withhold other medical treatments that have the potential to prolong life.[8]

6.2 Requests for CPR in situations where it will not be successful

Neither patients, nor those close to them, can demand treatment that is clinically inappropriate. If the healthcare team believes that CPR will not re-start the heart and breathing, this should be explained to the patient in a sensitive way. These discussions informing the patient of the healthcare team's decision may be difficult and where possible should be carried out by experienced senior clinicians. If the patient does not accept the decision and requests a second opinion, this should be arranged whenever possible. Similarly, if those close to the patient do not accept a DNAR decision in these circumstances, despite careful explanation for its basis, a second opinion should be offered.

7. Decisions about CPR that are based on benefits and burdens

If CPR may be successful in re-starting the patient's heart and maintaining breathing for a sustained period, the benefits of prolonging life must be weighed against the potential burdens to the patient. This is not solely a clinical decision and must involve consideration of the patient's broader best interests including their known or likely wishes. In these circumstances, discussion with the patient (or, if the patient lacks capacity, those close to the patient) about whether CPR should be attempted is an essential part of the decision-making process.

Patients should be informed in a sensitive manner of the facts and of the possible risks and adverse effects in order to make informed decisions about whether or not they would want CPR. Many people (including patients, those close to them and even some healthcare professionals) have unrealistic expectations about the likely success and potential benefits of CPR and lack detailed understanding of what is involved. The picture gained from the media (television drama for example) seldom reflects a realistic view of the success rate, or the physical nature of CPR. While health professionals, understandably, are reluctant to alarm patients or deter them from treatment which may be life-prolonging, it is important that everybody involved in making decisions is aware of what is involved and of the factors that may affect the outcome.

Prolonging life is not always beneficial. The courts have confirmed that it is lawful to withhold CPR on the basis that it would not be in the patient's best interests, where consideration has been given to the relevant medical factors and to whether the treatment may provide a reasonable quality of life for a patient who lacks capacity.[9]

In assessing the potential benefits of attempting to prolong life, it is not only legitimate but ethically appropriate to consider whether cardiorespiratory arrest is likely to recur and whether the patient is likely to experience unmanageable or long-term pain or other distressing adverse effects. Some patients may, however, despite potentially distressing adverse effects, have specific reasons for wanting to try to delay death, even if this is only for a very short period of time. If such a wish is expressed, accurate information must be provided about the likelihood and length of survival that might realistically be expected, and about the potential risks and effects of attempted CPR. The patient should be invited to discuss the risks and benefits of CPR in order to reach an agreed decision on whether or not it should be attempted.

Consideration of the balance of benefits and burdens in these cases also involves balancing rights under the Human Rights Act 1998. The Act guarantees protection for life (Article 2) but also declares that 'no one shall be subjected to torture or to inhuman or degrading treatment or punishment' (Article 3). This terminology is intended to apply to situations in which human beings are deliberately ill-treated and have severe indignities inflicted upon them. However, some people have a profound abhorrence of being kept alive in a state of total dependency or permanent lack of awareness, or of an undignified death. If patients express such views, health professionals should take this into account when making decisions about CPR. They should not attempt to prolong life if it is clear that the

patient would not want this or would not find the likely outcome acceptable. The duty to protect life must be balanced with the obligation not to subject the patient to inhuman or degrading treatment.

A decision that CPR will not be attempted, on best interests grounds, because the burdens outweigh the benefits should be made only after careful consideration of all relevant factors, discussion with the patient, or those close to patients who lack capacity, and these include:

- the likely clinical outcome, including the likelihood of successfully re-starting the patient's heart and breathing for a sustained period, and the level of recovery that can realistically be expected after successful CPR
- the patient's known or ascertainable wishes, including information about previously expressed views, feelings, beliefs and values
- the patient's human rights, including the right to life and the right to be free from degrading treatment
- the likelihood of the patient experiencing severe unmanageable pain or suffering
- the level of awareness the patient has of their existence and surroundings.

The views of members of the medical and nursing team involved in the patient's care, including those involved in a patient's primary and secondary care, are valuable in forming a decision about the likely clinical effectiveness of attempting CPR and about best interests where the patient lacks capacity. Attempts should be made to discuss a patient's CPR status, where possible, with these healthcare professionals.

The fact that a decision has been made to attempt CPR in the event of cardiorespiratory arrest does not mean that all other intensive treatments and procedures will also be appropriate. For example, prolonged support for multi-organ failure (e.g. artificial ventilation, renal dialysis or haemofiltration, and circulatory support with inotropic drugs and/or an intra-aortic balloon pump) in an ICU may be clinically inappropriate if the patient is unlikely to survive this, even though the heart has been re-started. After resuscitation from cardiac arrest most patients will require at least a brief period of monitoring and observation in a CCU or ICU. When discussing the benefits and burdens of CPR with patients, it is important to ensure that this is understood. It is particularly important to take into account the possibly limited benefit of CPR in those patients for whom organ support in an ICU would not be clinically appropriate as they are unlikely to survive their admission to ICU. This should be done through sensitive discussion to help patients to understand this.

Another difficult subject is the question of whether or not it is appropriate to make a decision to restrict the type or extent of CPR that is to be applied in specific circumstances. Some people believe that patients should be considered either 'for CPR' or 'not for CPR' and that there should be no 'half-measures'. Clearly, if CPR is to be attempted, it should be performed competently. It is inappropriate to initiate resuscitation and then not to try hard to achieve a successful outcome. However, all other decisions can be made on the balance of risk and benefit. For example, a patient receiving ventilatory and other organ support on an ICU might be considered for immediate defibrillation of a shockable cardiac arrhythmia causing cardiac arrest, as this would be likely to restore them to the situation that was present immediately before the arrest, and there may be treatable factors that predisposed to the arrhythmia. However CPR might not be considered appropriate in the same patient if they were to suffer cardiac arrest in asystole or with pulseless electrical activity, with such a low probability of a successful outcome.

Outside an ICU, restriction of CPR to treatment of shockable rhythms only is advocated by some clinicians in some specific clinical settings. Any such decision must be thought through clearly on the basis of the balance of risks, burdens and benefits to the individual patient and should be discussed with the patient (or those close to patients who lack capacity). If a decision is made to restrict the

nature or extent of CPR for an individual the reasons justifying that restriction should be documented fully in the patient's health record, and detailed instructions on the implementation of the decision should be recorded by the healthcare professional making the decision and communicated effectively to all members of the healthcare team caring for the patient. Advance decisions about the duration of CPR to be applied in the event of a cardiorespiratory arrest are best avoided. The duration of the resuscitation attempt should usually be decided by the resuscitation team, based on the clinical circumstances of the arrest, the progress of the resuscitation attempt and the perceived balance of risk and benefit from continuing CPR.

7.1 Communication and discussion with patients or those close to patients who lack capacity

When a patient with capacity is at foreseeable risk of cardiac or respiratory arrest, and the healthcare team has doubts about whether the benefits of CPR would outweigh the burdens, or whether the level of recovery expected would be acceptable to the patient, there should be sensitive exploration of the patient's wishes, feelings, beliefs and values. However, information should not be forced on unwilling recipients and if patients indicate that they do not wish to discuss CPR this should be respected. Patients with capacity should be given opportunities to talk about CPR, but should not be forced to discuss the subject if they do not want to. Any discussions with the patient about whether to attempt CPR and any anticipatory decisions should be documented, signed and dated in the patient's health record. If a DNAR decision is made and there has been no discussion with the patient because they have indicated a clear desire to avoid such discussion, this must be documented in the health record and the reasons must be recorded.

If a patient lacks capacity, any previously expressed wishes should be considered when making a CPR decision. Whether the benefit would outweigh the risks and burdens for the particular patient should be the subject of discussion and agreement between the healthcare team and those close to or representing the patient. Only relevant information should be shared with those close to patients unless, when they were previously competent to do so, a patient has expressed a wish that information be withheld.

Consulting with those close to the patient in these cases is not only good practice but is also likely to be a requirement of the Human Rights Act (Articles 8 – right to private and family life and 10 – right to impart and receive information), the Mental Capacity Act 2005 (England and Wales), and the Adults with Incapacity (Scotland) Act 2000 (see section 9). Clinicians should ensure that those close to the patient, who have no legal authority, understand that their role is to help inform the decision-making process, rather than being the final decision-makers. Great care must be taken when people other than the patient make or guide decisions that involve an element of quality-of-life assessment, because there is a risk that health professionals or those close to the patient may see things from their own perspective and allow their own views and wishes to influence their decision, rather than those of the patient. These considerations should always be undertaken from the patient's perspective. The important factor is whether the patient would find the level of expected recovery acceptable, taking into account the invasiveness of CPR and its low likelihood of success, not whether it would be acceptable to the healthcare team or to those close to the patient, nor what they would want if they were in the patient's position.

Communication about CPR and DNAR decisions is complex and sensitive. It should be undertaken by experienced members of the healthcare team who have the necessary skills and knowledge to undertake discussions with patients and with those close to or acting for patients. Organisations providing healthcare have a responsibility to ensure that members of their clinical staff have adequate training and up-to-date knowledge to make appropriate decisions about CPR and communicate them effectively.

7.2 Requests for CPR where the burdens may outweigh the benefits

Some patients may ask for CPR to be attempted, even if the clinical evidence suggests that in their case there is only a very small chance of success. Although the healthcare team may doubt whether the risks and burdens associated with CPR are justified by the very small chance of success, the individual whose life is at stake may be willing to accept that chance. Realistic information must be provided sensitively to patients about the nature of CPR and the likely risks, including the risk of long-term neurological damage, but if patients still ask that no DNAR decision be made, this should usually be respected. If patients subsequently suffer cardiac or respiratory arrest, further clinical decisions should be made in accordance with the advice in these guidelines.

These difficult situations are a potential source of confusion. Doctors cannot be required to give treatment contrary to their clinical judgement, but should be willing to consider and discuss patients' wishes to receive treatment, even if it offers only a very small chance of success or benefit. Where attempted CPR has a reasonable chance of successfully re-starting the heart and breathing for a sustained period, and patients have decided that the quality of life that can reasonably be expected is acceptable to them, their wish for CPR should be respected. In the unusual circumstance in which the doctor responsible for a patient's care feels unable to agree to the patient's expressed wishes for attempted CPR, or where there is lack of agreement within the healthcare team, seeking a second opinion is recommended so that patients may be given an opportunity to review their decision in the light of further advice. Transfer of the patient's care to another doctor or team can be considered if there is still a lack of agreement and it is feasible. In exceptional circumstances, where there is ongoing disagreement, it may be necessary to seek legal advice.

8. Refusals of CPR by adults with capacity

Clearly patients will lack capacity at the time of suffering cardiac or respiratory arrest but anticipation of the possible occurrence of this event may enable patients to decide in advance that they do not want CPR to be attempted.

It is well established in law and ethics that adults with capacity have the right to refuse any medical treatment, even if that refusal results in their death. Where healthcare teams believe that CPR may be successful in re-starting patients' heart and breathing for a sustained period, discussion should take place with the patients to determine their views and wishes regarding CPR. If patients decide that they do not wish to have CPR attempted, this should be documented carefully in the hospital, GP or health establishment's records and steps should be taken to ensure that this is communicated to those who need to know (see section 15). Patients are not obliged to justify their decisions, but health professionals usually wish to discuss the implications of a refusal of treatment with patients in order to ensure that the decision is based on accurate information and not on any misunderstanding. However, they must take care not to pressure patients into accepting treatment that they do not want. Some people may be happy for their refusal of CPR simply to be documented in the health record by the healthcare team. In England and Wales, unless these records are signed by patients and the signature is witnessed, they are unlikely to meet the legal criteria for a valid advance decision and so some patients may prefer to make a formal, written advance decision. Similarly, if patients are not currently being treated in a healthcare establishment and they want to ensure that their wishes are respected, they may decide to make a formal, written advance decision following the criteria stipulated in the Mental Capacity Act 2005 (England and Wales). The onus is on patients to ensure that healthcare teams are aware of the existence and content of any advance decision.

8.1 Advance decisions refusing CPR

CPR must not be attempted if it is contrary to valid and applicable advance decisions made when patients had capacity (see below for criteria for validity).

In **England and Wales**, advance decisions are covered by the Mental Capacity Act 2005. The Act confirms that an advance decision refusing CPR will be valid, and therefore legally binding on the healthcare team, if:

- the patient was 18 years old or over and had capacity when the decision was made
- the decision is in writing, signed and witnessed
- it includes a statement that the advance decision is to apply even if the patient's life is at risk
- the advance decision has not been withdrawn
- the patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf
- the patient has not done anything clearly inconsistent with its terms
- the circumstances that have arisen match those envisaged in the advance decision.

If an advance decision does not meet these criteria but appears to set out a clear indication of the patient's wishes, it will not be legally binding but should be taken into consideration in determining the patient's best interests.

In **Scotland and Northern Ireland**, advance decisions are not covered by statute but it is likely that they are binding under common law. Although no cases have been taken to court in Scotland or Northern Ireland, it is likely that the principles that emerged from consideration of cases by the English courts (before the Mental Capacity Act) would also guide decision-making in these jurisdictions. Should case law change in this area, this guidance will be revised to reflect any changes.

An advance refusal of CPR is likely to be legally binding in Scotland and Northern Ireland if:

- the patient was an adult at the time the decision was made (16 years old in Scotland and 18 in Northern Ireland)
- the patient had capacity when the decision was made
- the circumstances that have arisen are those that were envisaged by the patient
- the patient was not subjected to undue influence in making the decision
- the patient has not done anything clearly inconsistent with its terms.

If an advance decision does not meet these criteria but appears to set out a clear indication of the patient's wishes, it will not be legally binding but should be taken into consideration in determining the patient's best interests.

8.2 Assessing validity and applicability

Although advance decisions often do not come to light until the individual has lost capacity, there should be a presumption that the individual had capacity when an advance decision was made unless there are grounds to suspect otherwise.

Health professionals must decide whether the advance decision is applicable to the circumstances that have arisen. Particular care will be needed where an advance decision has not been reviewed regularly or updated and attention should be given to any relevant clinical developments or changes in the patient's personal circumstances since the decision was made. For example, patients may have taken actions or made other important decisions that indicate that they had changed their minds.

Where there is genuine doubt about the validity and applicability of an advance decision and when time permits, further enquiries should be made and, if necessary, an application made to the Court of Protection (in England and Wales), the Sheriff Court (in Scotland) or the High Court (in Northern Ireland) for a judgment. In an emergency, where there is no time to investigate further, the presumption should be in favour of CPR if this has a realistic chance of prolonging life. If it is agreed that an advance decision is invalid or not applicable, the reasons why it is considered invalid or not applicable should be documented.

9. Adults who lack capacity

The sections above have set out the level of involvement of patients and those close to them in making or guiding decisions about CPR. This will vary depending on whether the decision not to attempt CPR is based solely on medical factors (i.e. CPR would not be successful) or on the balance of benefits and burdens, which involves a broader 'best interests' judgement. This section explains who should be consulted when adults lack capacity and explains the main provisions of the Mental Capacity Act 2005 (England and Wales) and the Adults with Incapacity (Scotland) Act 2000 concerning proxy decision-makers.

Decision-making capacity refers to the ability that individuals possess to make decisions or to take actions that influence their life, from simple decisions about what to have for breakfast to far-reaching decisions about serious medical treatment, for example CPR. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person or for other people. Patients over 16 years of age are presumed to have capacity to make decisions for themselves unless there is evidence to the contrary. Individuals are, however, considered legally unable to make decisions for themselves if they are unable to:

- understand the information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making the decisions, or
- communicate the decisions (whether by talking, using sign language, visual aids or by other means).

9.1 Patients with a welfare attorney or court-appointed deputy or guardian

If patients lack capacity and have a welfare attorney or guardian, this person must be consulted about CPR decisions. In **Northern Ireland** there is currently no provision for anybody to make decisions on behalf of patients who lack capacity although those close to patients should be consulted where a best interests decision is being made by the clinician in charge of the patient's care.

In **England and Wales** the Mental Capacity Act allows people over 18 years of age who have capacity to make a lasting power of attorney (LPA), appointing a welfare attorney to make health and personal welfare decisions on their behalf once such capacity is lost. Before relying on the authority of this person, the healthcare team must be satisfied that:

- the patient lacks capacity to make the decision
- a statement has been included in the LPA specifically authorising the welfare attorney to make decisions relating to life-prolonging treatment
- the LPA has been registered with the Office of the Public Guardian
- the decision being made by the attorney is in the patent's best interests.

In **England and Wales** neither welfare attorneys nor deputies can demand treatment that is clinically inappropriate but where CPR may be able to re-start the heart and breathing for a sustained period and a decision on whether or not to attempt CPR is based on the balance of benefits and burdens, their views about patients' likely wishes must be sought. Where there is disagreement between the healthcare team and an appointed welfare attorney or court-appointed guardian about whether CPR

should be attempted in the event of cardiorespiratory arrest, and this cannot be resolved through discussion and a second clinical opinion, the Court of Protection may be asked to make a declaration. More information about welfare attorneys, deputies and the Mental Capacity Act can be found in the Mental Capacity Act code of practice.[10]

In **Scotland** the Adults with Incapacity (Scotland) Act allows people over 16 years of age, who have capacity, to appoint a welfare attorney to make decisions about medical treatment once that capacity is lost. The Sheriff may, on application, appoint a welfare guardian with similar powers. Before relying on the authority of a welfare attorney or guardian, the healthcare team must be satisfied that:

- the patient lacks capacity to make the decision (the terms of a power of attorney may state how incapacity is to be determined)
- the welfare attorney or guardian has the specific power to consent to treatment (a register of valid proxy decision makers is held by the Public Guardian and may be checked during office hours)
- the decision being made by the attorney would benefit the patient
- the attorney has taken account of the patient's past and present wishes as far as they can be ascertained.

In **Scotland**, welfare attorneys and guardians cannot demand treatment that is clinically inappropriate. Where CPR may be able to re-start the heart and breathing for a sustained period and a decision on whether or not to attempt CPR is based on the balance of benefits and burdens, the welfare attorney's views about a patient's likely wishes must be sought. Where there is disagreement between the healthcare team and an appointed welfare attorney about whether CPR should be attempted in the event of cardiac or respiratory arrest, this should be resolved as quickly as possible by discussion and, if necessary, a second clinical opinion.

If the healthcare team wishes to attempt CPR but the welfare attorney or guardian refuses to give consent, the Mental Welfare Commission for Scotland must appoint a 'nominated medical practitioner' to give an opinion. This opinion is final unless appealed to the Court of Session. If the healthcare team does not believe that attempting CPR would benefit the patient, and the welfare attorney disagrees, either party could petition the Court of Session for a decision. More information about the Adults with Incapacity (Scotland) Act can be found in the Adults with Incapacity Act code of practice.[11]

9.2 Adults who lack capacity, have neither an attorney nor an advance decision but do have family or friends

Where a patient has not appointed a welfare attorney or made an advance decision, the treatment decision rests with the most senior clinician in charge of the patient's care. Where CPR may re-start the patient's heart and breathing for a sustained period, the decision as to whether CPR is appropriate must be made on the basis of the patient's best interests. In order to assess best interests, the views of those close to the patient should be sought, unless this is impossible, to determine any previously expressed wishes and what level or chance of recovery the patient would be likely to consider of benefit, given the inherent risks and adverse effects of CPR.

In reaching a decision:

- In **England and Wales** the Mental Capacity Act requires that best-interests decisions must include seeking the views of anyone named by the patient as someone to be consulted, anyone engaged in caring for the person or interested in the patient's welfare. Under the Act, all healthcare personnel, for example doctors, nurses and ambulance crew, must act in the best interests of a patient who lacks capacity.

- In **Scotland** the Adults with Incapacity (Scotland) Act requires doctors to take account, so far as is reasonable and practicable, of the views of patients' nearest relatives and their primary carers. If a senior clinician believes that CPR should be attempted, any person claiming an interest in the patient's welfare may appeal that decision to the Sheriff. A DNAR decision could also be challenged in the Court of Session.
- In **Northern Ireland**, where there is no statutory provision for decision-making for patients who lack capacity, it is nonetheless good practice to discuss decision-making with those close to the patient in order to determine what would be in the best interests of the patient.

In these circumstances, it should be made clear to those close to the patient that their role is not to take decisions on behalf of the patient, but to help the healthcare team to make an appropriate decision in the patient's best interests. Relatives and others close to the patient should be assured that their views on what the patient would want will be taken into account in decision-making but that they cannot insist on treatment or non-treatment.

9.3 Adults who lack capacity and have no family, friends or other advocate whom it is appropriate to consult

In **England and Wales**, the Mental Capacity Act 2005 requires an independent mental capacity advocate (IMCA) to be consulted about all decisions about 'serious medical treatment' where patients lack capacity and have nobody to speak on their behalf and the decision is made by an NHS body or Local Authority. The definition of serious medical treatment includes circumstances where 'what is proposed would be likely to involve serious consequence for the patient'. It can be argued that a decision not to attempt CPR because it will not work will not have 'serious consequences' for the patient, because the patient will die with or without attempting CPR. For this reason, in our view, an IMCA does not need to be called when it is clear to the medical team that CPR would not re-start the patient's heart and breathing for a sustained period. Nevertheless, neither the Act, nor the code of practice, differentiates between decisions made purely on clinical grounds (i.e. because the treatment is unable to achieve its clinical aim) and those that involve broader best-interests considerations and so it needs to be acknowledged that there is still some uncertainty in this area. Where there is genuine doubt about whether or not CPR would have a realistic chance of success, or if a DNAR decision is being considered on the balance of benefits and burdens, in order to comply with the law an IMCA must be involved in every case. If a DNAR decision is needed when an IMCA is not available (for example at night or at a weekend), the decision should be made and recorded in the health record. The decision should be discussed with an IMCA at the first available opportunity. An IMCA does not have the power to make a decision about CPR but must be consulted by the clinician in charge of the patient's care as part of the determination of the patient's best interests.

10. Children and young people

Ideally, clinical decisions relating to children and young people should be taken within a supportive partnership involving patients, their families and the healthcare team. Where CPR may re-start the heart and breathing for a sustained period but there are doubts about whether the potential benefits outweigh the burdens, the views of the child or young person should be taken into consideration in deciding whether it should be attempted.

Young people with capacity are entitled to give consent to medical treatment, and where they lack this capacity, it is generally those with parental responsibility[12] who make decisions on their behalf. In **England, Wales and Northern Ireland**, refusal of treatment by competent young people up to the age of 18 is not necessarily binding upon doctors since the courts have ruled that consent from people with parental responsibility, or the court, still allows doctors to provide treatment.[13] Where a young person with capacity refuses treatment, the potential harm caused by violating the young person's

choice must be balanced against the harm caused by failing to give treatment. In **Scotland**, it is likely that neither parents nor the courts are entitled to override a mentally competent young patient's decision.[14] Throughout the UK, if the healthcare team believes that they should attempt CPR for a competent young person who has indicated that they do not want this, legal advice should be sought.

Usually, it is possible to reach agreement on whether or not CPR should be attempted if a child or young person suffers respiratory or cardiac arrest. If there is disagreement between the patient, those with parental responsibility and the healthcare team despite attempts to reach agreement, legal advice should be sought. Parents cannot require doctors to provide treatment contrary to their professional judgement, but doctors should try to accommodate parents' wishes where there is genuine uncertainty about the young person's best interests.

If legal advice is required, this should be sought in a timely manner.

11. Confidentiality

If patients have capacity to make decisions about how their clinical information is shared their agreement must always be sought before sharing information with family and friends. It may also be helpful to ask patients with capacity who they want, or do not want, to be generally involved in decision-making if they become incapacitated (although it should be made clear that unless this person is formally appointed as a welfare attorney their role will be limited to providing information for the health professional who decides about treatment). Refusal by a patient with capacity to allow information to be disclosed to family or friends must be respected.

Where patients lack capacity and their views on involving family and friends are not known, doctors may disclose confidential information to people close to the patient where this is necessary to discuss the patient's care and is not contrary to the patient's interests. Where there is a welfare attorney, deputy, or guardian involved in the discussions, relevant information should be provided to them to enable them to fulfil their role. Even where their views have no legal status in terms of actual decision-making, it is good practice to involve people close to patients in discussions that inform decisions. Where IMCAs are involved they have a legal right to information, including access to the relevant parts of the patient's records in order to enable them to carry out their statutory role.

12. Information for patients

Written information about CPR policies should be included in the general literature provided to patients about healthcare organisations, including hospitals, hospices, general practices, ambulance services and care homes. The BMA has produced a model patient information leaflet addressing some of the common questions that patients ask or may want to ask. It can be amended to include local information and is available on the BMA's website (www.bma.org.uk). Such information should be readily available to all patients and to people close to the patient including relatives and partners. Its purpose is to de-mystify the process by which decisions are made and should make clear that for most patients the question will not arise. Information should reassure patients of their part in decision-making, what facilities are available, and where it is likely that CPR would be successful. Nevertheless, all patients and those close to them can ask for time to be set aside to discuss any aspects of CPR that they wish to.

13. Responsibility for decision-making

The overall clinical responsibility for decisions about CPR, including DNAR decisions, rests with the most senior clinician in charge of the patient's care as defined by local policy. This could be a consultant, GP or suitably experienced nurse. He or she should always be prepared to discuss a CPR decision for any individual patient with other health professionals involved in the patient's care. Teamwork and good communication are of paramount importance.

Where care is shared, for example between hospital and general practice, or between general practice and a care home, the health professionals involved should discuss the issue with each other and with other members of the healthcare team. There should be shared responsibility for deciding about the likelihood of a successful outcome from CPR, and discussing the issue with the patient or with those close to patients who lack capacity where a balance of benefits and burdens is needed. Nevertheless, one individual needs to take charge of ensuring that the decision is made properly, is recorded and is conveyed to all those who need to know it, including locum staff. Local policies should specify who that should be.

14. Recording decisions

Any decision about whether or not to attempt CPR must be readily accessible to all health professionals who may need to know it, including staff of hospitals, hospices and nursing homes, GPs and other community health professionals, out-of-hours medical services, and ambulance staff. The healthcare record should contain clear documentation of the decision and how it was made, the date of decision and the reasons for it, and the name and position of the person responsible for making the decision. There is some benefit in having a standard form for such decisions. Such a form would be already familiar to staff who move between healthcare settings. It may give assurance to those responsible for implementing a CPR decision that appropriate procedures have been followed and the decision has been authorised appropriately. The Resuscitation Council (UK) is developing a model form that individual establishments may wish to adopt. Details of this can be obtained from the Resuscitation Council (UK) whose contact details are at the front of this guidance. The form should be filed in the patient's health record and should be accessible immediately and easily. All decisions about CPR should be reviewed on a regular basis (see section 16) that is sensitive to the possibility of changes in the patient's condition.

In some paediatric settings parents have been asked to sign DNAR forms. This is not advisable and can cause unnecessary additional distress. Parents are not obliged to sign such forms. If parents are asked to sign a DNAR form it should be explained why they are signing the form and that they are not responsible for making the decision not to attempt CPR.

15. Communicating decisions to other health care providers

The person who makes a CPR decision is responsible for ensuring that the decision is communicated effectively to other relevant health professionals in both primary and secondary care. In hospital, local policies should indicate a clear line of responsibility and specific individuals' responsibilities. The task of disseminating information about the decision to others providing care to the patient may be delegated to another member of the healthcare team, but it should be clear who has responsibility for ensuring that this task is being undertaken. The senior nurse is responsible for ensuring that every CPR decision is recorded in the nursing records (where the institution has separate nursing records) and that all those nursing the patient are aware of the decision.

Any decisions about CPR should be communicated between health professionals whenever a patient is transferred between establishments, between different areas or departments of one establishment, or is discharged. In the past, problems have arisen with such transfers because CPR decisions have not

been communicated or have not been accepted as valid by the ambulance service or by the receiving organisation. Clinical guidelines issued by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC)[15] advise ambulance staff that they should always initiate CPR unless:

- There is a formal DNAR decision, or valid and applicable advance decision made by the patient, which has been seen by the ambulance crew, and the circumstances in which CPR may be attempted are consistent with the wording of the DNAR decision or advance decision; or
- The patient is known to be terminally ill and is being transferred to a palliative or terminal care facility (unless specific instructions have been received that CPR should be attempted).

To enable ambulance staff to comply with these guidelines, procedures must be in place to notify the ambulance staff of the patient's CPR status, and provide them with the necessary documentation, before the journey commences.

Local policies should set out how this information is to be communicated and who is responsible to ensure that this happens. In drawing up a local protocol, liaison with the ambulance service and out-of-hours service providers is essential. There is also an advantage to discussing the protocol with the police and coroner or procurator fiscal's office to ensure that deaths in the community, when a DNAR decision has been made, are treated as expected deaths.

There are many examples, at a local and regional level, of ways of ensuring that decisions are disseminated to all those involved in the care of patients. For example, agreeing standard resuscitation forms that are recognised locally or regionally by all healthcare establishments, the police, out-of-hours service providers, and ambulance service. These forms may be transferred with the patient, copied to relevant people, or held in an agreed central location.

16. Review

Decisions about CPR must be reviewed regularly and especially whenever changes occur in the patient's condition or in the patient's expressed wishes. The frequency of review should be determined by the health professional in charge and will be influenced by the clinical circumstances of the patient. Nevertheless, local policies may include some general safeguards for ensuring that review occurs appropriately. It is important to note that patients' ability to participate in decision-making may change with changes in their clinical condition. It is not usually necessary to discuss CPR with the patient each time the decision is reviewed, although where a patient has previously been informed of a decision and it subsequently changes, they should be informed of the change of decision and the reason for it.

Any CPR decision made at the time of initial admission of a patient to hospital should be reviewed by the most senior clinician in charge of the patient's care at the earliest opportunity.

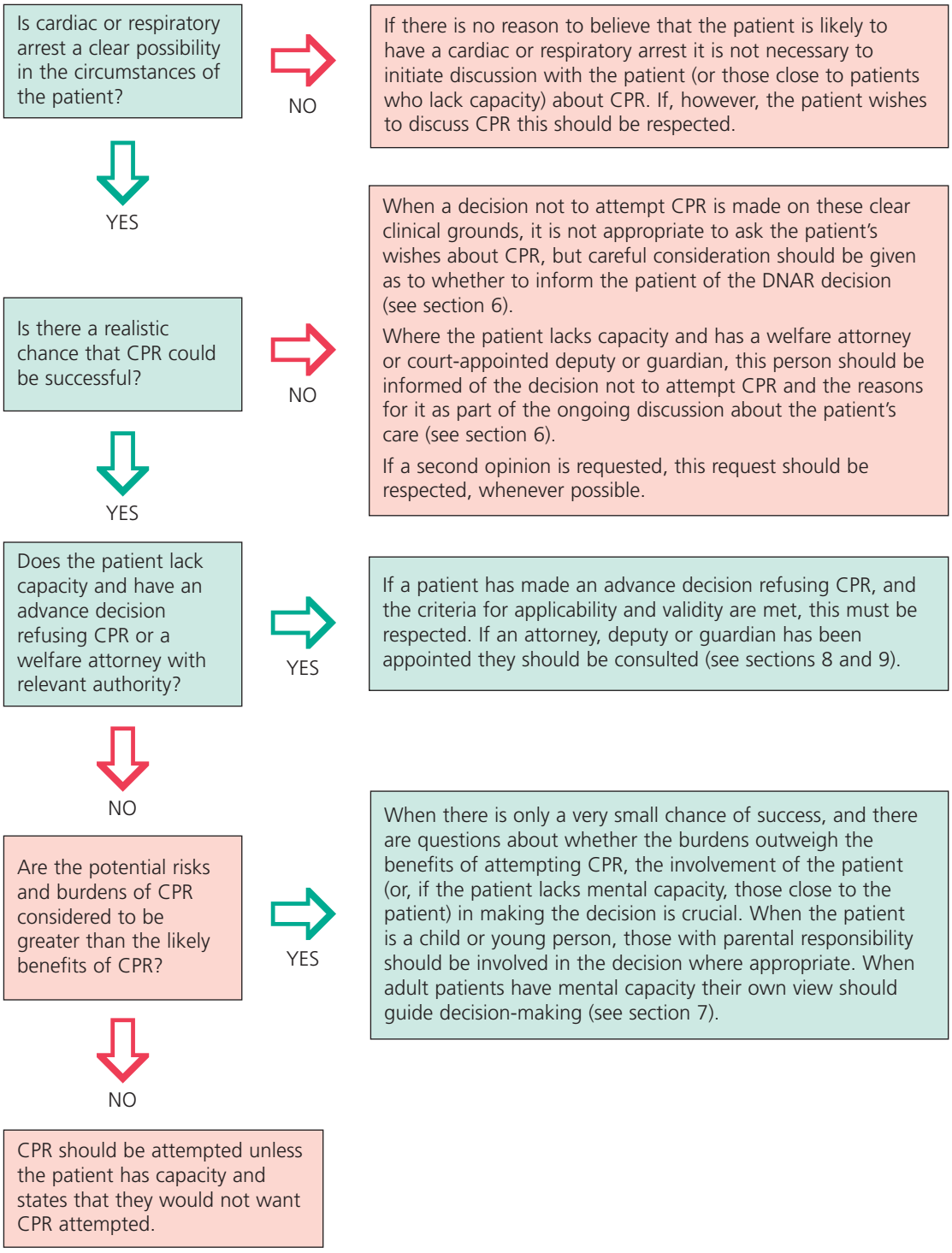
There may also be occasions when an initial decision has been made to attempt CPR but the patient's clinical circumstances change, subsequent to that decision, and it is no longer clinically appropriate to perform CPR when the patient suffers cardiorespiratory arrest as it would not be successful.

17. Standards, audit and training

CPR should be performed competently and in accordance with current national and international guidelines. Performance of CPR and experience with DNAR decisions should be the subject of clinical audit.

Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team. Healthcare organisations should ensure that their clinical staff have the training and maintain the knowledge and skills to undertake discussions and decision-making about CPR.

Decision-making framework



- Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully
- Decisions should be reviewed regularly and when circumstances change
- Advice should be sought if there is uncertainty.

Other published guidance

British Medical Association. *Withholding and Withdrawing Life-prolonging Medical Treatment (third edition)*. London: BMA, 2007.
Medical Ethics Department
British Medical Association
BMA House
Tavistock Square
London WC1H 9JP
Telephone: 020 7383 6286
Fax: 020 7383 6233
Email: ethics@bma.org.uk
Internet: www.bma.org.uk/ethics

General Medical Council. *Withholding and Withdrawing Life-Prolonging Treatments.* London: GMC, 2002.
General Medical Council
Regent's Place
350 Euston Road
London NW1 3JN
Telephone: 0845 357 3456
Email: gmc@gmc-uk.org
Internet: www.gmc-uk.org

Healthcare Commission. *Guidance for resuscitation in establishments other than acute hospitals.* London: Healthcare Commission, 2006.
Healthcare Commission
Finsbury Tower
103-105 Bunhill Row
London EC1Y 8TG
Telephone: 020 7448 9200
Email: feedback@healthcarecommission.org.uk
Internet: www.healthcarecommission.org.uk

The Intensive Care Society. *Critical Care Focus 13: Ethical Issues in Intensive Care.* London: The Intensive Care Society, 2007.
The Intensive Care Society
Churchill House
35 Red Lion Square
London WC1R 4SG
Telephone: 020 7280 4350
Email: admin@ics.ac.uk
Internet: www.ics.ac.uk

Joint Working Party between the National Council for Hospice and Specialist Palliative Care Services and the Ethics Committee of the Association for Palliative Medicine of Great Britain and Ireland. *Ethical decision-making in palliative care: cardiopulmonary resuscitation (CPR) for people who are terminally ill.* London: National Council for Hospice and Palliative Care Services, August 1997.
National Council for Hospice and Palliative Care Services
First Floor
34-44 Britannia Street
London WC1X 9JG
Telephone: 020 7520 8299
Fax: 020 7520 8298
Email: enquiries@ncpc.org.uk
Internet: www.ncpc.org.uk

Joint Royal Colleges Ambulance Liaison Committee. *Recognition of Life Extinct (ROLE) by Ambulance Staff.* London: JRCALC, 2003.
JRCALC
Ambulance Service Association
7th Floor
Capital Tower
91 Waterloo Road
London SE1 8RT
Telephone: 020 7928 9620
Fax: 020 7928 9502
Email: jrcalc@asa.uk.net
Internet: www.jrcalc.org.uk

Resuscitation Council (UK). *Resuscitation Guidelines 2005*. London: Resuscitation Council (UK), 2005.
Resuscitation Council (UK)
Tavistock House North
Tavistock Square
London WC1H 9HR
Telephone: 020 7388 4678,
Fax: 020 7383 0773
Email: enquiries@resus.org.uk
Internet: www.resus.org.uk

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2 Sandroni C, Nolan J, Cavallaro F, Antonelli M. In-hospital cardiac arrest: incidence, prognosis and possible measures to improve survival. *Intensive Care Med* 2007;**33**:237-245.

3 Nolan J, Laver S, Welch C, Harrison D, Gupta V, Rowan K. Outcome following admission to UK intensive care units after cardiac arrest: a secondary analysis of the ICNARC Case Mix Programme Database. *Anaesthesia* (due for publication end of 2007).

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8 British Medical Association. *Withholding or withdrawing life-prolonging medical treatment (3rd ed)*. London: Blackwell Publishing, 2007.

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10 Department for Constitutional Affairs. *Mental Capacity Act 2005 Code of Practice*. London: TSO, 2007.

11 The Scottish Executive has published five codes of practice, training materials, public information leaflets and other guidance to assist with the implementation and operation of the Adults with Incapacity (Scotland) Act 2000. See www.scotland.gov.uk/justice/incapacity (accessed 6 July 2007).

12 The BMA has separate guidance on parental responsibility. British Medical Association. *Parental responsibilty: guidance from the Ethics Department*. London: BMA, June 2006. The guidance is available at www.bma.org.uk/ap.nsf/Content/Parental (accessed 6 July 2007).

13 Information about significant legal developments relevant to these guidelines will be made available on the BMA's website at www.bma.org.uk/ethics.

14 For more detailed guidance on decision making for children and young people see British Medical Association. *Consent, rights and choices in health care for children and young people.* London: BMJ Books, 2001.

15 Joint Royal Colleges Ambulance Liaison Committee. *UK Ambulance Service Clinical Practice Guidelines*. London: JRCALC, 2006.

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