Letters

CPR decision-making by elderly patients

SIR

Gwen Sayers and colleagues are to be congratulated on demonstrating what most working clinicians have known for years; that it is impractical and unnecessary to attempt to discuss cardiopulmonary resuscitation (CPR) decisions with most elderly patients.¹ Their findings support established clinical practice in the UK where most CPR decisions are made by doctors without consultation with patients.²

We would, however, take issues with several points raised in their paper. They state that most Do Not Resuscitate (DNR) decisions on elderly patients are made on the basis of perceived poor quality of life, rather than because CPR is regarded as being a treatment which will not work (futility). We disagree. A survey undertaken in a neighbouring London hospital to that of Sayers and colleagues found that 30% of all elderly inpatients, and 59% of those with DNR decisions, had morbidity scores which were in the range which indicated that CPR would be likely to fail, if it were to be attempted.³ It seems likely that these patients had DNR decisions made because CPR was regarded as futile. Morbidity scores are instruments which produce aggregate scores depending on the presence of the various clinical factors known to predict poor outcome from CPR; higher scores indicate high morbidity and hence poorer outcome from CPR. They were developed in the United States where they have been shown accurately to predict failure to survive CPR⁴ and we have subsequently validated three such scores in our district general hos-

pital in Winchester.⁵ We found that of 264 consecutive patients having CPR attempts, none of those with high scores survived.

Sayers and colleagues have been more realistic than most other authors in their attempts to discuss CPR with patients, but they still have not achieved a completely realistic scenario by doing this when patients are in the convalescent stage of their illness. The most important time to consider DNR decisions is on hospital admission or in the acute phase of an illness. This is probably the time when cardiac arrest is most likely to occur and certainly the time when CPR is most likely to be successful. For those who survived CPR in our hospital the mean time from admission to cardiac arrest was 1.7 days and 57% of them arrested on the day of admission.⁵ Making decisions about patients who have been in hospital for several days and are clinically stable or recovering is much less relevant, because few of them are likely actually to arrest and few of those who do will survive. If, as Sayers and colleagues have demonstrated, it is impractical to discuss decisions with this group then it will be even more difficult to discuss them with acutely ill patients on admission.

The study would be more easily related to everyday clinical situations if the authors had told us what percentage of patients screened were selected for inclusion, how many were excluded and the reasons for the exclusions. In the Newham survey³ 32% of all elderly medical inpatients, and 55% of those with DNR orders, had a mental test score of less than 7 out of 10 (indicating at least moderate confusion) or else were too ill to complete a score, so would have been unlikely to

have been able to participate in clinical decisions.

Do not resuscitate decisions are of most clinical relevance when made at the time of hospital admission for patients who are acutely ill. We believe that many elderly patients are not competent to discuss decisions at this time and even those who are considered competent can be spared these, often distressing, discussions on the grounds that CPR would be futile. This is realistic, not paternalistic, to say that most DNR decisions for such patients should be made by doctors who usually do not need to discuss them with patients.

References

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