References and notes

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Resuscitation policy

SIR
There has been much debate since the circular sent from the Chief Medical Officer, reference PL/CMO (1991) of 20 December 1991, regarding resuscitation policy, following a complaint from a relative who discovered his mother was assessed as being unsuitable for cardiopulmonary resuscitation (CPR) (1). Accurate and detailed medical reports are required in this era of litigation in which we find ourselves, particularly since the Parliamentary Act of 1991 which permits review of medical notes by patients and their next-of-kin.

There were no formal guidelines regarding the assessment of patients for CPR at our District General Hospital. On a single day in March 1992, the notes of all medical in-patients at our hospital were examined to ascertain which type of patient had been deemed unsuitable for CPR (not for 333s) by their supervising team. In particular, information concerning:

- reason for not considering patient for CPR.
- how it was stated.
- indication of who had been involved in the decision and, in particular, if either the patient or the close relatives were knowledgeable of the decision.
- if the original resuscitation policy was reviewed during the course of the patient's stay in hospital.

Further, it was to be established if the nursing staff were also fully aware of the patient's resuscitation status.

At that time the hospital held 178 medical beds supervised by 8 consultant physicians on 6 wards, the majority of bed occupancy being patients received from the general acute medical take (greater than 85 per cent); routine admissions accounted for only a small percentage. The specialty of acute geriatric medicine was managed at other sites in the city.

Of 133 patients (86 per cent bed occupancy), ages ranging between 17 and 92, only 8 (6 per cent) were apparently not suitable for CPR according to the medical documentation. In others, no decision or mention of appropriate action in the event of cardiopulmonary arrest was given. Out of this total of 8, the nurses were apparently unaware of this instruction in 4 cases.

This random survey showed that reasons for a policy not to resuscitate were not actually documented in the notes and that, at times, decisions had apparently been left to a pre-registration house officer. Although consultant advice may, indeed, have been sought, this was not clearly documented in the notes.

- Of the 8 entries 'not for 333s' was recorded in 7 cases. The remaining one read 'patient not for ventilation'.
- It would not have been clear to an outside observer as to who had made the decision, or on which specific day or hour this had been entered.
- The nursing staff in 4 (50 per cent) of cases were unaware of the medical decision.
- There were 9 patients (7 per cent) who were actually deemed suitable for resuscitation, despite having terminal disease who would, at least initially, be put through the trauma and indignity of a resuscitation procedure in the event of cardiac arrest.

Individuals are rarely consulted, even in an indirect way, about their own resuscitation policy. Surprisingly, one survey of elderly patients found that only 7 per cent requested full CPR in the event that they were found to be in asystole (2).

Since 1974 in the USA institutional policies for CPR have been introduced (3). In Britain formal policies are rare, as noted by the Ombudsman in his report.

This study clearly emphasises that there is an urgent need for a directive either at hospital or national level regarding the delicate decision of whether to resuscitate. The Clinical Medical Board is at present considering specific guidelines for resuscitation policies in Britain.

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