Response to Aneurin Bevan University Health Board DNACPR Policy Consultation

from
Christian Medical Fellowship

The Christian Medical Fellowship (CMF) has over 4,500 doctor members and around 1,000 medical student members and is the UK's largest faith-based group of health professionals. A registered charity, it is linked to about 70 similar national bodies in other countries throughout the world. 154 doctor members reside in Wales and there are 63 student members at the two Welsh medical schools.

Summary of Concerns

- **That a DNACPR order alter the perception of a patient by clinical staff such that decisions about treatments other than CPR are influenced**
- **That clinician prejudice may influence decision-making**
- **That value-of-life criteria, rather than evidence-based survival prospects can influence DNACPR decisions, jeopardizing justice**
- **That medical staff may shirk difficult or painful discussions with patients and their families by hiding behind the 'unnecessary burden' exception clause**
- **That the desire to maximize the availability of organs for transplantation may influence DNACPR decisions**

In this submission, we offer some general observations first, and suggest some additional general wording for the policy paper. Secondly, we propose specific wording amendments to three paragraphs of the policy paper.

General Observations

We welcome this attempt to bring clarity and consistent practice to DNACPR decision-making in Wales (http://www.wales.nhs.uk/sitesplus/866/news/32396) and specifically the emphasis on diligence, sensitivity and candour in discussions with the patient and their family. Lack of consultation over instituting such orders is a well-publicised problem and the attention given in the policy document to a framework reflecting both the priority and process of communication is most welcome. We also welcome the presumption in favour of CPR where it is likely to prolong/benefit a patient's life (**8.3**).

There remain two main areas of concern.

1. DNACPR (or similar) orders can result in a reduced quality of care and attention that a person is likely to receive. One study found that a patient was thirty times

more likely to die, if she had a DNACPR order in her notes, than another person who was equally unwell, independent of prognosis, disease severity, age or other confounding factors [1]. In another study, many nurses connected DNACPR not only to CPR but also to the intensity of intervention for any medical condition [2]. These findings suggest that **the assignation 'do not attempt resuscitation' influences decisions about treatments other than resuscitation.**

Question: *How will the policy seek to audit the possibility that assigning a DNACPR order may reduce the focus and quality of care and attention that a patient receives?*

Recommendation: *We suggest that the audit template (**10.1**) be amended to include the collection of data to examine outcomes that test this risk.*

2. There is clearly a risk that a DNACPR order be given to a patient who has a serious, life-threatening or life-shortening disease, that is not shortly to terminate her life, but who is admitted to hospital for treatment for another, eminently treatable disorder. Illustrations of this regularly make the news, for example the case of Jill Baker who had stomach cancer when admitted to hospital for (successful) treatment of septicaemia, and who discovered after leaving hospital that she had been given a DNACPR order, without discussion with herself or her family [3]. A similar example involves a 51 year old man with Down's Syndrome and dementia whose family recently sued an NHS Trust, on the man's behalf, over a hospital's decision to assign a 'do not attempt resuscitation' order, without consultation with the patient, his carers or his family, and giving his disability as one of the reasons [4].

These examples illustrates two issues, the obvious one being the lack of appropriate discussions between the clinical teams and the patients' families and carers, an issue that is comprehensively addressed in the policy proposal (eg **4.3 and 4.4)**. The other issue raised is the possibility that **clinician prejudice, the clinician's perception of the patient's present or anticipated quality of life, influences the DNACPR decision.**

Clearly, there is widespread agreement amongst doctors that DNACPR-type orders are wholly appropriate for the person who is expected to die imminently from a progressive incurable disease (**5.1**). This consensus is based on a consideration of the best interests of the patient and the desire to avoid futile and possibly harmful interventions.

What is disturbing is the suggestion that older people, people with disability, ethnic minorities, people who do not speak English, alcoholics and HIV positive patients have been shown to receive DNACPR orders more often than other groups of patients [5]. In such studies the suggestion is that **hidden prejudices and value-of-life assessments, rather than evidence-based survival prospects, are influencing decision-making.**

That there is no advice or warning about value-of-life criteria in this policy seems to us a significant omission.

Such prejudice appears to be particularly true in the care of elderly patients with dementia, one study concluding that quality of life criteria were pre-eminent in deciding on a DNACPR order, a 'subjective judgment, with staff varying in their opinions of what constituted quality of life.'[2] Medical specialty and years of experience and training have also been shown to influence attitudes towards DNACPR [6]. In the study mentioned above [2], consultants treating adult psychiatry patients gave no DNAR orders whereas their colleagues working in continuing care of the elderly on the same words gave them to 40% of their patients.

Studies show that clinicians tend to underestimate quality of life in their patients [7]. In patients with dementia, evaluation of current cognitive ability at the time when DNAR orders are being considered might add a degree of objectivity to the assessment. However, **it is our conviction that quality of life criteria should not be the basis for decision-making about DNACPR orders.** At a pragmatic level, such assessments are inevitably subjective, vary according to cultural, ethnic and religious settings, and are impossible to standardise. **Justice is jeopardised.**

At a level of principle, who has the right to decide if another's life is worth living? 'Doctors may determine whether a treatment is futile, but they can never determine whether a life is futile. When we withdraw or withhold treatment, we are expressing a belief that the treatment is valueless, not that the patient is valueless.' [8]

Question: *What safeguards will the author(s) build into the policy to ensure that decisions about DNACPR orders are reached on the basis of evidence-based survival prospects and not subjective value-of-life judgments?*

Recommendations:

1. That the DNACPR discussion, as outlined in para 5.3, page 11, should be conducted between the patient (or his family/representative) and a minimum of two clinical staff, to minimise the possibility that any one member of staff might be influenced by value-of-life judgments. After the sentence in bold type in the policy we suggest adding a sentence that reads: ***the discussion should involve a minimum of two clinical staff, one acting as 'lead' and the other as observer, to minimize the risk that value-of-life judgments influence the decision.***

2. That in the audit section 10.1 b, Clinical and Professional Aspects, an additional point be added: ***Evidence that DNACPR decisions are being made on evidence-based criteria and not upon value-of-life criteria***

Para 1.1

A stated objective of this policy is 'to clarify that patients will not be asked to decide on CPR when it would be likely to fail.'

Question: *Will any use be recommended of pre-arrest morbidity scoring systems that could be useful in formalising the assessment of the value or futility of CPR?*

Para 4.2

Clearly, such discussions can be sensitive and difficult to handle for all concerned, clinical staff included. There could be a temptation to hide behind the 'unnecessary burden' clause in order to avoid a potentially painful discussion when really it ought be had.

Recommendation: *Where the decision is taken to avoid having the discussion, we suggest amending the wording of the policy to read: that the reasons for avoiding discussion with the patient* ***must be agreed together by members of the clinical team*** *and documented.*

Para 5.5 Section A

The last sentence of this paragraph refers to organ donation. The understandable desire to maximise the number of available organs for transplantation, in the context of the Wales Government's stated intention to change to an 'opt-out' system of donation, raises concern lest the two decisions become entwined.

Recommendation*:* *We strongly recommend that the following sentence be added at the end of this section:* ***Decision-making for these two procedures must be kept entirely separate.***

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1 Shepardson LB, Younger SJ, Speroff T & Rosenthal GE. Increased risk of death in patients with do-not-resuscitate orders. Med Care 1999; 37:727-737

2 Chakraborty N and Creaney W. 'Do not resuscitate' decisions in continuing care psychiatric patients: what influences decisions? The Psychiatric Bulletin 2006; 30: 376-378

3 Meikle J. Do not resuscitate: final word is with medical staff, whatever patient feels. The Guardian, 26 August 2011.

4 Draper J. Health Correspondent, BBC News. 13 September 2012.

5 Ebrahim S. Do not resuscitate decisions. BMJ 2000;320:1155

6 Kelly W F *et al*. Do specialists differ on do-not-resuscitate decisions? Chest 2002; 121: 957-963

7 Juno Perron N *et al*:. Quality of life of Do-Not-Resuscitate patients: how good are physicians in assessing DNR patients' quality of life? Swiss Medical Weekly 2002; 132: 562-565

8 Wyatt J. Matters of Life and Death. Leicester: *IVP*, 1998:192-212