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INTRODUCTION AND GUIDING PRINCIPLES

Cardiopulmonary resuscitation (CPR) is a procedure to initiate breathing and circulation in a person who has stopped breathing (respiratory arrest) and / or whose heart has stopped (cardiac arrest). CPR is a therapy designed for patients who have potentially reversible cardiopulmonary arrest and for whom there is a reasonable possibility of therapeutic benefit.

Each patient's CPR status should be determined based upon individual patient circumstances and following a full and realistic discussion regarding the patient's underlying prognosis, values, chances for overall benefit from CPR, and chances for overall harm from CPR.

Contemporary medical ethics has guiding principles, which include respect for autonomy, beneficence, non-maleficence, and justice. With regard to the procedure of CPR:

> Autonomy refers to the principal that a patient's value preference and choices among health care alternatives should be respected. Respect for autonomy does *not* require that patient or their surrogate be offered intervention that is not indicated.
>
> Beneficence implies that an action is done for the benefit or good of the patient. If an intervention cannot be expected to enhance the good or welfare of the patient, then it is not offered. An intervention may have a measureable *effect* on some part of the patient without being *beneficial.*
>
> Non-maleficence means to do no harm. Most medical interventions have some risk of harm. An intervention may be offered if its intent is not to inflict harm, and if the balance between benefit and harm is favorable. By its nature CPR causes a degree of harm in all cases, and grave harm in select cases.
>
> Justice requires the fair and non-wasteful use of resources. Non-beneficial treatment efforts use healthcare resources that are better used in other ways

Decisions regarding other life-sustaining medical treatments are independent of decisions regarding CPR. This policy concerns only the ability to write a No CPR order in two circumstances:

1) when CPR is physiologically futile or

2) when CPR is non-therapeutic.

From an ethical perspective, this is not different from not offering other surgical and medical procedures which are physiologically futile or non-therapeutic.

The process and procedures defined within this policy do not apply to pregnant women, minors, and patients with a court appointed guardian, but may be used as guidelines for care.

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POLICY

1. Physiologically Futile CPR

   CPR will not be attempted when it is physiologically futile, that is, when the patient's condition is such that CPR will be ineffective. CPR is physiologically futile in the following situations:

   A. Death by neurological criteria (See Policy # 317)

   B. Progressive multi-system organ failure, which is occurring despite maximal therapy with no expectation of survival.

      a. Multi-system organ failure means irreversible shock, metabolic acidosis, respiratory and renal failure.

      b. Maximal therapy means that both

         i. all life-threatening disease processes are being treated per standard of care, and

         ii. physiologic support is being provided by maximal beneficial doses of vasopressors, fluids, mechanical ventilation, and renal replacement therapy if applicable.

2. Non therapeutic CPR

   CPR is also not indicated for use when, based on published research and the current clinical information, CPR will not be effective in reversing the on-going dying process *and* will not lead to survival to discharge.

PROCEDURE

1. Physiologically futile CPR

   A. If the patient's condition meets the criteria described in 1.B. above and does not have a No CPR order, the patient's legal surrogate should be informed that CPR will be ineffective in this case and that, for this reason, a No CPR order will be written. In addition, a reasonable attempt to notify the patient's primary care physician is made.

   B. If the surrogate does not object, the No CPR order is written.

   C. If the patient's legal surrogate objects to a No CPR order, the physician-in-chief will be notified, the physician-in-chief must acknowledge receipt of that notification, and the following process is implemented:

      a. Two attending physicians, one of whom is a critical care specialist and the other may be of any specialty, agree that the patient's condition meets the criteria described above. This determination can only be made at the time of an onsite evaluation by the critical care specialist or by the attending physician who is ordering No CPR.

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1. Physiologically futile CPR (cont'd)

   b. If a consultant already participating in the patient's care believes that the patient does not meet the criteria described above, a No CPR order will not be entered. If there is subsequent agreement, a No CPR order will be entered and the discussion documented.

   c. When condition 1Ca in this section is met and the consultant(s) already participating in the patient's care are in agreement that the patient meets these criteria, a No CPR order is entered by the attending physician or critical care specialist and the patient's surrogate is notified of the order.

2. Non-therapeutic CPR

   A. If the patient's condition leads the attending physician to conclude that CPR would be non-therapeutic, the physician must inform the patient or the patient's surrogate that CPR is not medically indicated, and that a No CPR order is warranted. In addition, a reasonable attempt to notify the patient's primary care physician is made.

   B. If the patient or the patient's surrogate does not object, the attending physician enters a No CPR order.

   C. If the patient or the patient's surrogate objects to the No CPR order, the following process is implemented:

      a. Palliative Care is consulted to discuss the diagnosis, disease trajectory, common complications and the therapeutic efficacy of CPR with the patient or the patient's surrogate. The purpose of this consultation is primarily educational.

      b. If the Palliative Care consultation results in acceptance of the plan for No CPR by the patient or patient's surrogate, a No CPR order is then entered by the consultant, and the attending is notified.

      c. If the patient or the patient's surrogate does not agree to meet with Palliative Care or if, after such a meeting, continues to object to a No CPR order, the following steps should be followed.

         i. The attending physician will notify the Physician-in-Chief, and provide an adequate synopsis of the case; the Physician-in-Chief must acknowledge receipt of that notification. Should the Physician-in Chief be unavailable, the Chief Medical Officer or another Beaumont Health System Physician-in-Chief may substitute. In order to assure that appropriate legal concerns are addressed, it is the responsibility of the Physician-in-Chief, or his / her covering representative, to contact Legal Affairs.

         ii. The attending physician should confirm that members of the patient's clinical team are in agreement that CPR should not be performed on the patient because it is non-therapeutic.

         iii. A second opinion should be obtained from a physician with clinically relevant expertise who is not a member of the patient's clinical team about whether CPR is non-therapeutic.

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2. Non-therapeutic CPR (cont'd)

iv. If this second opinion supports the conclusion of the clinical team, and the patient or patient's surrogate now agree to a No CPR order, then the No CPR order is entered in the medical record and appropriately documented. However, if the patient or patient's surrogate continues to disagree with a No CPR order, the attending physician must contact the Ethics Consultation Service for a case review.

v. The role of the Ethics Consultation Service in this situation is to determine whether the requirements of this policy are being met. That is, it is the responsibility of the ECS to assess:

- whether the physician offering the second opinion arrived at his or her opinion independently, and, if so,
- whether there is any reason to think that either opinion is based on factors other than medical data.

vi. If the Ethics Consultation Service is satisfied that this policy is being followed, the patient or patient's surrogate will be told that a No CPR order will be entered in the medical record, subject to steps vii – ix below.

vii. If they wish, the patient or surrogate should be given three business days and assistance for a transfer of the patient to another facility willing to accept the patient.

viii. If the patient or the patient's surrogate identifies an accepting attending physician at an accepting facility, and if the patient is medically stable for transfer, Beaumont will facilitate the transfer of the patient to that facility.

ix. If it is not possible to transfer the patient, the attending physician, with the concurrence of the Physician-in-Chief, will enter a No CPR order.

NOTE: For the purposes of this policy it is expected that a No CPR order is always entered by an attending physician. If the order is entered by someone other than the primary attending, the primary attending should be notified when the order is entered.