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## Authors' response

This is in response to concern raised by Prof. Sampathkumar A, on the recently published Indian Council of Medical Research (ICMR) consensus guidelines on Do Not Attempt Resuscitation (DNAR)[1] that the decision is being left entirely in the hands of the treating physician. A close reading of the document would dispel this apprehension. DNAR is a considered decision by the patient or by the medical team in his/her best interests, not to have cardiopulmonary resuscitation (CPR) performed in the event of an anticipated cardiorespiratory arrest (CRA)[2].

Hitherto, the practice in India has been to regard CPR as the only option in the event of a CRA without considering the background scenario. The ICMR consensus document has sought to change this practice, in keeping with the longstanding option of DNAR in

the world[2-4]. This initiative is aimed at correcting an anomaly that serves only to add to avoidable burdens in many clinical situations for a dying patient.

If the document is taken in its entirety, it would emerge that DNAR decisions are centered around the patient's autonomy and best interests. CPR, like other medical procedures, is provided by the physician if indicated[1-4]. There is clearly no duty of care or obligation to provide CPR when it is futile. In a proportion of cases, the duty of care would be to refrain from CPR that would mar the dignity of dying, *e.g.,* in the last moments of the terminally ill or in catastrophic conditions with no hope of survival[2]. At the same time, in order to respect autonomy and to maintain public trust, the document recommends that physicians must discuss sensitively the reasons for DNAR orders. Where CPR has a realistic chance of a successful outcome, the medical team should provide CPR in an emergency situation. Where CRA can be anticipated, attempts should be made to discuss CPR/ DNAR with the competent patient with sensitivity and tact. An informed patient's clear choice of DNAR is to be honored, when there is either none or uncertain chances of a successful CPR[1]. If the patient is unwilling for such discussion or is incapacitated, the same should be done with a surrogate (legally appointed proxy or next of kin). When the benefit of CPR is uncertain, as in frailty and chronic ailments on a deteriorating trajectory, a shared decision-making model is to be adopted. When surrogates speak for an incompetent patient, physicians must integrate his/her best interests into the decisions. Such checks and balances ensure that the patient's autonomy as well as overall interests are protected. As with other medical decisions, the overall responsibility and accountability must rest with the physicians. The intersecting issues of Advance Care Planning (ACP) and Advance Medical Directives (AMD) are outside the purview of the document. A valid AMD, if available, is to be treated by physicians as the patient's opinion so far as it relates to DNAR. The document has clearly stated that DNAR is distinct from withdrawal or withholding of other life-supporting treatments.Taken together, the recommendations in the ICMR guidelines on DNAR thus address fully the concerns articulated in the letter. The queries relating to an individual's desire to be a potential organ donor is outside the stated scope of the document. Similarly, the ethical dilemmas around a convict as a potential donor are to be addressed separately.

**Indian Council of Medical Research Expert Group on DNAR**

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