Since 1974, when the first policies about ‘do not attempt resuscitation’ orders were published [1], the decision not to resuscitate patients in cardiac arrest has been a controversial issue in medical practice. For this reason, the ‘do not attempt resuscitation’ order is, perhaps, the directive and the decision to withhold medical treatment with the widest bibliography. In this review, in accordance with the 2000 Guidelines for Cardiopulmonary Resuscitation [2], I will use the term ‘do not attempt resuscitation (DNAR)’ instead of the more popular ‘do not resuscitate (DNR)’. The first sentence indicates more clearly the decision to take, because the success of a resuscitation is not always guaranteed.

In the practice of resuscitation, it has been accepted for many years that when a person has suffered a sudden cardiac arrest, resuscitation manoeuvres should always be started ‘except in narrowly defined circumstances’ [3]. This concept has not changed in the current guidelines [2, 4]. This concept is unique in the practice of medicine, and it is based on the facts that it is an emergency and also a benefit for the patient [5]. The rationale lies in the belief that life is precious and that resuscitation will be successful. However, the latter is not true and the rate of survival ranges between 15-25% [6] and many of the initially resuscitated patients have residual impairment if the resuscitation is not completely achieved [7], thus prolonging the suffering of both patients and relatives [8]. Today we know well that all attempts at resuscitation should be previously assessed and agreed with the patient or relative, if this is possible [9].

What Are the Real Possibilities of Success in Resuscitation?
The rationale for always starting cardiopulmonary resuscitation (CPR) manoeuvres in a cardiac arrest in patients without a poor prognosis due to
underlying diseases is based on the good results in many individual patients, with both good neurological recovery and quality of life. However, the rate of survival after a cardiac arrest has been not higher than 25% in the better results [10] and the average standard rate is 6% of survivors emerging from an out-of-hospital cardiac arrest [11] and it may be as lower as 1.4% in New York City [12]. In hospital cardiac arrests the current survival after resuscitation to hospital discharge is 17% in the USA, according to the National Registry of Cardiopulmonary Resuscitation [13].

In recent years, an improvement in positive outcome after cardiac arrest has been observed in some special sites, as in the casinos of Las Vegas, with the use of automated external defibrillators by trained non-healthcare personnel, with a 53% of survival to discharge from the hospital [14]. A significant increase in survival has been observed in the PAD Trial [15] with the use of automated external defibrillators in public access defibrillator programmes in comparison with standard resuscitation [16]. The functional state of survival patients in these series are good. The quality of life and the neurological state of the majority of long-term survivals are similar to the general population of the same age, as was observed in a group of 200 out-of-hospital cardiac arrest cases with ventricular fibrillation, with a survival rate to discharge of 42% [17].

In this context, it seems that the statement that resuscitation manoeuvres should always be started in a person who has suffered a sudden cardiac arrest are still applicable [2], unless a DNAR order had been dictated due to the poor recovery possibilities of the patient or that the patient himself/herself or his/her surrogate had given an advanced directive against the move CPR [8].

However, some voices have a different opinion based on the fact that many resuscitation survivors have permanent neurological disability [7] and suggest that resuscitation manoeuvres should not be initiated without a prior informed consent from the patient in which he/she specifically authorises resuscitation in the case of cardiac arrest, to avoid a heavy burden on the family and society in the form of a patient without hope [18]. As is natural, this proposal has been contested because it implies denying the possibility of survival to some patients, mainly favouring those who suffer a cardiac arrest with some particular circumstances which predispose them to a higher chance of success and a low likelihood of neurological impairment [19].

**Do Not Attempt Resuscitation Order: Ethical or Legal Issue?**

Although it is important to analyse the legal aspects, they can differ from one country to another and may not be clearly defined in their legal regulations,