Who’s for CPR?

Cardiopulmonary resuscitation (CPR) is back in the news. Public interest was last aroused by revelations of inadequate training and technical incompetence, culminating in the College’s 1987 report. Recent interest has a different focus: deciding who should receive CPR. In his 1991 annual report, the Parliamentary Commissioner for Health (the Ombudsman) drew attention to a woman of 88 admitted to hospital with pneumonia. She was designated ‘not for resuscitation’; the patient’s son discovered this and made a complaint. A newspaper reported [1] that neither the admitting doctor nor other junior doctor colleagues thought that relatives should normally be involved in such decisions. The Ombudsman ‘found surprising the novelty of establishing a written resuscitation policy’, and the matter was subsequently discussed by a parliamentary committee: doubtless we shall all hear more.

Soon after its description in 1960, CPR became an increasingly effective treatment to prevent sudden unexpected death in a number of life-threatening situations. But when it was subsequently used on a much wider range of conditions, its success rates predictably fell.

Death with dignity

If a sober view of success tempered the indiscriminate use of CPR, so also has the plea for ‘death with dignity’. As Medawar implied [2], dignity may not matter to patients, but undoubtedly matters to others. Anyone with experience of CPR will have met difficulties—and occasional mayhem—followed by the paraphernalia of the intensive care unit (ITU) before the patient’s death a day later. If the expected outcome is death, a procedure less dignified and peaceful could hardly be devised.

As a result, the USA has had since 1974 institutional policies for CPR [3]. The Massachusetts Appeal Court upheld the legality of a ‘do-not-resuscitate’ (DNR) order in 1978 [4] while in 1988 New York State placed such orders under legal regulation [5]. In Britain, by contrast, institutional policies remain a rarity. Serious ethical discussion hardly ever appears in British journals, in contrast to the extensive debate and guidelines [6] published in American journals. Bayliss [7] characterised the British approach in 1982: ‘In Britain, sound unhurried clinical judgment, sympathy, understanding and mutual trust, rather than abstract principles and printed policy statements, have in general stood patients in good stead.’

Bayliss also believed that it should be the consultant who would decide whether or not to resuscitate after discussion with house staff and ward sister: ‘Better than anyone else the consultant and his team know the nature of the patient’s disease or diseases and the likelihood of their responding to treatment. Quality of life is relative and should be assessed in relation to the age, state of health, and personal aptitudes and interests of each individual patient.’ This is a humane view from a distinguished physician. It is, nevertheless, indefensibly paternalistic. Moreover, doctors are highly inconsistent in making CPR decisions [8].

Possible harm of CPR

CPR is not a harmless technological placebo. CPR may harm the subject, relatives, health-care staff, and society. Each of these four parties has an interest. For many patients, initial restoration of a beating heart may be rapidly followed by a further cardiac arrest. Thus fear of death visits the mentally orientated patient twice; others awake confused and hallucinating in a strange environment. Then come such procedures as multiple venepunctures, arterial samples, catheterisation and monitors, causing further discomfort and pain, and increasing confusion and apprehension. Inflicting or perpetuating pain, grief or suffering, or interrupting a timely death where there is minimal potential benefit, constitutes cruelty.

Families may also suffer. A patient from a loving family does not suffer alone: the family may have to endure the thwarted hopes of initial success and the hours of apprehensive waiting by the body of an unconscious relative in ITU.

Relatively soon after the introduction of CPR the comment was made that ‘an unfortunate lowering of morale and enthusiasm of all hospital staff may follow a series of unsuccessful attempts to resuscitate hopeless cases’ [9]. Undertaking tasks without conviction leads to cynicism. Without ‘no codes’ there will be ‘slow codes’: the team will arrive late, go through the motions for the sake of appearances, and before long lose its efficiency. It is also harmful to call overtired young doctors from bed at 5 am for no rational purpose.

Society may also suffer. Intensive care is expensive, especially for the persistent vegetative state. Inappropriate use of resources deprives others of their benefits. Society has a right to expect wise use of its resources.

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So who’s for CPR? First and foremost, of course, patients who want and need it [10]. The importance of the patient’s wishes stems from the principle of autonomy. Just as patients have the right to consent to medical treatment, they also have the right to refuse it, even when such treatment is essential to sustain their lives. Such refusal may serve as the basis for a DNR order.

In practice, doctors rarely discuss CPR with their patients, especially in the UK. What is more, even when physicians profess a belief in discussing CPR they do not do so: in one such study [11] only 19% of patients had discussed resuscitation before the cardiac arrest. The physician’s perception may not have corresponded with the patient’s stated preference, nor was there consistent agreement between two physicians about that preference. These attitudes were independent of the estimated probability of cardiac arrest occurring, the location in the hospital, or the underlying disease.

This partly relates to the circumstances in which the question of CPR arises. A discussion too far in advance may seem irrelevant to the patient’s immediate status. The acute situation may be complex. A deaf, wheezy patient is taken to hospital with severe chest pain: does he, at 85 years of age, really want CPR? How do we inform him of the possibility, the technique, its outcomes, the discomforts of intensive care, ventilators, mental impairment, institutionalisation etc, and then assure ourselves that he is truly competent to give informed consent? The problem is no easier to deal with out of hospital [12].

An adequate understanding, either by experiencing the procedure or by detailed explanation of it, leaves many patients refusing CPR: of 38 patients asked if they wanted a repeat attempt, only 55% said ‘yes’ [13]. A simple question, such as ‘In the event of your heart stopping, would you like us to do everything to get it started again?’, is inadequate. Given full explanation, few elderly subjects consent to it: only 7% said ‘yes’ in one study [14]. Policies in the USA mandate CPR unless a DNR order is written and the patient or family have given permission before that order is written [15]. Without it, the centenarian or patient with carcinoma is liable to receive the full rigours of CPR. Current British practice may be indefensibly paternalistic, but is more humane. This is no excuse for avoiding an emotionally demanding task, but is an acknowledgement that decisions have to be made in situations where ‘informed consent’ easily degenerates into a charade of signing a valueless ‘consent form’.

Patient autonomy

Removing power from the physician by complex DNR procedures does not necessarily enhance patient autonomy. Autonomy must sometimes be rapidly judged where the patient’s protection against abuse of professional power lies only in the integrity of the doctor. Autonomy is not enhanced by offering pseudo-choices, where one offers no reasonable prospect of a particular outcome. Insisting that surrogates sign forms to authorise DNR orders was described by the wife of one dying patient as ‘being my husband’s murderer or having him tortured’ [16]. No one expressed this better than Ingelfinger [17] in his memorable essay on arrogance:

‘I do not want to be in the position of a shopper at the Casbah who negotiates and haggles with the physician about what is best. I want to believe that my physician is acting under a higher moral principle than a used car dealer. I’ll go further than that. A physician who merely spreads an array of vendibles in front of his patient and then says “Go ahead, choose, it’s your life” is guilty of shirking his duty, if not of malpractice.’

Any competent patient who rationally refuses CPR probably decides on a judgment of the quality of his life. ‘I believe that no man ever threw away his life while it was worth keeping’, wrote David Hume [18]. This quality will refer either to the present quality of living or to the likely quality of life in the near future in the light of existing disease. For an elderly patient life expectancy may be too short or life too mediocre to justify the risks of CPR. Unquestionably DNR orders on competent patients on quality of life grounds should only be made with the patient’s consent. Only an individual can evaluate his own priorities. Disabled people, particularly, value life more than their able counterparts might think. Doctors are poor judges of the effects their patients’ quality of life may have on their decisions regarding resuscitation [19].

For incompetent patients, the family—all things being equal—is the best guardian of the patient’s interests as well as the best proxy. By the ‘substituted judgment’ doctrine, the surrogate ascertains the incompetent person’s preferences, making decisions as if that person were competent. The doctor is not interested in the relative’s own opinion but in the relative’s interpretation of what the patient’s opinion would have been. Had the incompetent patient, for example, ever said what should happen under such circumstances? Or, by the ‘best interests’ test, the surrogate evaluates the alternatives and selects that in which the benefits outweigh the burdens and thereby best promote the patient’s welfare. This standard is familiar to British doctors as the duty of care for any incompetent patient undergoing any procedure. Both the ‘substituted judgment’ and the ‘best interests’ tests will lead to disagreements; occasionally these have been strong enough for relatives’ views to be overruled by doctors [20]. In this respect advance directives, though lacking status in English law, would be valuable.
Futility

Futility of treatment outcome is another reason for a DNR order: describing a treatment as futile implies its prohibition. The patient is not merely a customer. Although many people articulate a right to health care in general, the patient has no automatic right to choose a specific treatment modality. In licensing doctors, society implicitly entrusts them to promote health and relieve suffering. Useless or harmful treatment does not achieve this end. If the aim of medicine is health, and health is a form of beneficence, then no patient can have a right to treatment that may be useless or harmful. Without potential medical benefit, the raison d'être of the physician-patient interaction disappears [21].

But can we say that CPR is potentially never beneficial? Roughly one-third of patients are revived; one-third of those leave hospital, and 80% of them are alive at six months but 2% remain in a persistent vegetative state. But certain groups do badly after CPR: thus, of 58 patients who had pneumonia, none survived [13], while in the elderly, although 31% [22] and 22% [23] survived initially, only 0% and 1.6% could be discharged home. Perhaps CPR is pointless when patients have pneumonia, while the elderly benefit only if ventricular fibrillation or ventricular tachycardia are witnessed. The rest are futile.

Or are they? Claiming ‘futility’ suggests (hard) facts, not (soft) values. Or is it a conflict between professional power and patients or relatives? A statement of futility may simply imply the need to study more patients. In the series quoted none of 58 patients with pneumonia survived. But assuredly none will if this is taken to mean that none can. A rational treatment may be used before its value has been proven. For someone in the persistent vegetative stage, CPR is repugnant. Yet the decision to refuse it is not value-free. Such a life could be greatly valued, still a focus for someone’s love, and the patient may have been prepared to fulfil this role [24]. Declining CPR denies such possibilities. Similarly, the judgment that an increased life expectancy of a few hours or days is insignificant is a judgment of value. The claim of ‘futility’ cannot change a value judgment to a factual one.

Moral purpose

That does not render the concept useless. A surgeon cannot be obliged to operate on a centenarian with renal failure, dementia and a ruptured thoracic aortic aneurysm just because failure to do so would imply a judgment of value. Not only do patients not have unqualified rights to demand specific treatments, but doctors also must have the discretion to interpret and apply medicine’s own values. If doctors have rightful control over the interventions they offer to patients, it is only because they have the authority to act on judgments of value [25]. If decisions about pursuing the merest possibility of survival always belonged to the patient or proxy, then doctors would have no authority to stop CPR. Although paternalism is open to abuse, an appeal to professional integrity carries the weight of medicine’s authority as a moral enterprise, part of whose social acceptability stems from its beneficent purposes. In practice, doctors do not easily accept doing less, rather than more, for a patient. Certainly they must examine the reasons for a DNR order; certainly each doctor must define for himself ‘minimal prospects’ for each individual. It is his duty. For some people CPR is a blessing; for others it is a curse, and its inappropriate use a waste of precious resources. Doctors cannot refrain from the sensitive value judgments implicit in the moral purpose of medicine.

References

1 Hospital resuscitation code call after ‘death sentence’. The Guardian, June 14, 1991.
2 Medawar P. The life instinct and dignity in dying. In: The threat and the glory. Pyke D, ed. Oxford: Oxford University Press, 1990:275.
3 Optimum care for hopelessly ill patients. A report of the Clinical Care Committee of the Massachusetts General Hospital. N Engl J Med 1976;295:362-4. Rabkin MT, Gillerman G, Rice NR. Orders not to resuscitate. N Engl J Med 1976;295:364-6.
4 Schram RB, Kane JC, Roble DT. ‘No code’ orders: clarification in the aftermath of Saikewicz. N Engl J Med 1978;299:857-8.
5 McClung J, Kamer RS. Legislating ethics. Implications of New York’s do-not-resuscitate law. N Engl J Med 1990;322:270-2.
6 Council on Ethical and Judicial Affairs, American Medical Association. Guidelines for the appropriate use of do-not-resuscitate orders. JAMA 1991;265:1868-71.
7 Bayless RIS. Thou shalt not strike officiously. Br Med J 1982;1:1373-5.
8 Yudkin JS, Doyal LT, Hurwitz BS. Interpreting survival rates for the treatment of decompenated diabetes: are we saving too many lives? Lancet 1987;ii:1192-5.
9 Harley HRS. Reflections on cardiopulmonary resuscitation. Lancet 1966;i:1-4.
10 Loewy EH. Invoking patients in do-not-resuscitate decisions: an old issue raising its ugly head. J Med Ethics 1991;17:56-60.
11 Bedell SE, Delbanco TL. Choices about cardiopulmonary resuscitation in hospital: when do physicians talk with patients? N Engl J Med 1984;310:1069-73.
12 Irsen KV. Forgoing prehospital care: should ambulance staff always resuscitate? J Med Ethics 1991;17:19-24.
13 Bedell SE, Delbanco TL, Cook EF, Epstein FH. Survival after cardiopulmonary resuscitation in hospital. N Engl J Med 1983;309:599-76.
14 Murphy DJ. Do-not-resuscitate orders: time for reappraisal in long-term care institutions. JAMA 1988;259:299-101.
15 Hackler JC, Hiller PG. Family consent to orders not to resuscitate: reconsidering hospital policy. JAMA 1990;264:1281-3.
16 Prager K. Implications of New York’s do-not-resuscitate law. N Engl J Med 1990;323:1838-9.
17 Ingelfinger FG. Arrogance. N Engl J Med 1980;304:1507-11.
18 Hume D. Of suicide (1784). Reprinted in: Applied ethics. Singer P, ed. Oxford: Oxford University Press, 1986:26.
19 Uhlmann RF, Pearlman RA. Perceived quality of life and preferences for life-sustaining treatment in older adults. Arch Intern Med 1991;151:495-7.
20 Brennan TA. Incompetent patients with limited care in the absence of family consent: a study of socioeconomic and clinical variables. Ann Intern Med 1988;109:819-25.
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21 Brett AS, McCullough LB. When patients request specific interventions: defining the limit of the physician’s obligation. N Engl J Med 1986;315:1347-51.
22 Taffett GE, Teasdale TA, Luchi RJ. In-hospital cardiopulmonary resuscitation. JAMA 1988;260:2069-72.
23 Murphy DJ, Murray AM, Robinson B, Campion EW. Outcomes of cardiopulmonary resuscitation in the elderly. Ann Intern Med 1989;111:199-205.
24 Angell M. The case of Helga Wanglie: a new kind of ‘right-to-die’ case N Engl J Med 1991;325:511-2.
25 Tomlinson T, Brody H. Futility and the ethics of resuscitation. JAMA 1990;264:1276-80.

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