

Do not resuscitate dilemmas

by Michael Webb-Peploe

A woman lies in a hospital bed. She is elderly and severely ill. Around her circulates a procession of doctors, nurses, family and friends. One question needs addressing: if her heart and breathing stop, should they try cardiopulmonary resuscitation? Decision-makers need to remember the dignity and value of all human life when making 'do not resuscitate' decisions, basing their conclusion on evidence-based survival prospects rather than value-of-life statements.

'Do not resuscitate (DNR¹) orders can be considered only after discussion with the patient or others close to the patient, and they should be reviewed at regular intervals.' This is the opinion of the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. Their advice is set against the background where traditionally clinicians determined their patients' resuscitation status without consulting the person or relatives – a situation that is now regarded as morally indefensible.

Despite this supposed change in attitude, Age Concern England compiled a report showing that DNR notices were regularly posted on the notes of elderly patients without this being discussed with either the people themselves or their relatives.² An independent review of one of these cases noted: 'It was hard to avoid the conclusion that the treatment plan... was to do little more than allow the patient's life to ebb away'.³

The report highlights two areas of concern. First was the lack of communication between medical staff and the people involved in each situation. Secondly there is the concern that the quality of care

given to a person declines once a DNR decision has been made.

Rather than coming to the conclusion that treatment is futile, it would appear that on occasions doctors decide that the person's life is futile.

We need to see how patients as well as healthcare workers view the issue of resuscitation, enabling both to gain a realistic understanding of each other's viewpoints and then find ways of caring for people whatever their state of health.

Anxiety and expectations

At the moment the public seems to be developing a growing distrust of the medical profession. Part of this is caused by the fact that doctors don't always listen to a patient's views before they come to decisions.

For example, one recent research paper shows that in America only 29% of residents of nursing homes had had discussions with a doctor or member of staff about whether they wanted to be given life-sustaining treatments. Despite this, 74% of the

people had DNR orders written in their notes.⁴

Communication is not just poor between doctor and patient; there is also a lack of communication between the patient and his or her caregivers. Only half of the people who had discussed a DNR order with their doctors had talked about it with their relatives or friends.

Another study looked at people with severe heart disease.⁵ Researchers found that the doctor's view of whether a person wanted to be resuscitated if necessary disagreed with the patient's actual view in one quarter of occasions. Sadly the mismatch between the patients' and the physicians' views did not appear to improve if they discussed the situation.

Another problem is that people tend to have an excessively optimistic view of the chances of resuscitation being successful. Television has led to the illusion that a decision to resuscitate will be followed by a sudden rush of medical staff, and an immediate outcome – either the person dies or survives. In most cases they seem to survive.

The reality is very different. To start with, resuscitation is seldom a single event, but is a long-drawn-out string of interventions. This can

include electrically stimulating the heart, mechanically helping the person breathe, and transferring them to an intensive care unit for further treatment. Many patients die a day or two later, with their last days occupied by intrusive and often painful interventions.

On average less than half of patients whose hearts stop while they are in hospital survive the initial event. Of those who survive, only one third live to go home. The remaining two-thirds experience a lingering death in hospital.⁶

Outside a hospital the situation is even worse. Resuscitation may succeed in as few as 2% of people whose hearts stop when they are not in a hospital.

In many cases the chance of resuscitation being successful is minimal and it must be more appropriate to let the person die with dignity. For example, there is basically no chance that cardiopulmonary resuscitation (CPR) will save the life of someone who has pneumonia or advanced cancer and then has heart failure.⁷ In these sorts of situations the attempt to resuscitate is a futile exercise denying the person a

dignified death. If the patient is elderly, there is a high chance that the force needed to compress the chest will break some ribs. This causes intense pain and complicates further treatment.

Consequently most doctors believe DNR orders are appropriate if the person is dying from a progressive incurable disease. What is disturbing, though, is the suggestion that DNR orders may result in a reduced quality care and attention that a person is likely to receive. One study found that a patient was more than thirty times more likely to die if she had a DNR order in her notes than another person who was equally unwell.⁸

Legal situation

Currently the UK's legal situation is not totally clear. However most commentators agree that doctors can make DNR orders without consulting their patients in two key situations. The first is if the person's health is

so poor that they are unlikely to survive CPR. The argument here is that recommending resuscitation for a patient with severe pneumonia is as inappropriate as recommending chemotherapy, a liver transplant or any other form of invasive therapy. The resuscitation is not going to achieve anything so it should not even be a matter of debate.

The second situation is where the doctor believes that a patient is mentally incompetent. In this situation, however there is normally the possibility of discussing the situation with relatives or friends.

In the USA the legal situation is laid down in a set of so-called 'right-to-die cases'. These establish that a person has a right to refuse life-sustaining treatment whether he or she is thought of as competent or incompetent. US law sees no difference between not starting (withholding) and stopping (withdrawing) a treatment.

The courts do distinguish between withdrawing treatment and active euthanasia or physician assisted suicide, neither of which are fundamental liberties protected by the American Constitution.⁹

Matters of life

A Christian assessment of the issues surrounding resuscitation needs to start from the realisation that however poor, ill, disabled or even in pain a person is, his or her life is never futile. Human beings are God-like beings. The Bible states that human beings are made in God's image – a statement that says more about values than physical attributes.

Being made in God's image means that we should respond to each other with wonder, respect, empathy and above all with an attitude that seeks to protect each other from abuse, harm, manipulation and from wilful neglect.

Facts and figures

Resuscitation has a poor chance of helping many people. The probability of cardiopulmonary resuscitation is greatly affected by the person's underlying condition and where the person is when their heart stops beating.

CPR success in hospital	CPR success 'at home'
6.5%-15%	2%-30%

If there is multi-organ disease the survival rates are substantially lower.

Reality is far from TV

A paper in the *New England Journal of Medicine*¹² showed the unrealistically high success rates of CPR on medical television dramas.

	TV	Real life
alive immediately after CPR	77%	40% or less
long term survival after CPR	67%	30% or less
CPR due to heart disease	28%	75%-95%
typical age	majority children or young adults	majority elderly

A person who is exceedingly ill is still a person. Even if a decision is made that attempts at resuscitation are so unlikely to succeed that it would be inappropriate to try, this does nothing to diminish the value placed on the person. Indeed recognising that a person is weak and incapable of self-defence is useful as it highlights our duty of care. In this case we have a responsibility to increase, rather than decrease, our effort to care for the person.

A consequence of this high view of life is that we must distinguish removing suffering from removing the sufferer. Any action that sets out with the intention of destroying a human life desecrates God's image. There can, however, be times when it is entirely appropriate to decide not to give some form of treatment, because that treatment has little or no chance of helping the person, and giving it could be distressing. In *CMF File 7*, Duncan Vere clearly shows the difference between intentionally killing a person and making an ethically sound decision to withdraw or withhold futile treatment.

In addition to looking at a person's life in isolation, we need to consider their position within society. Not only is each individual human life special, we are all part of the human family. We are created to live in community. To think that matters of life and death can be decided in isolation by a single individual is a dangerous illusion.

A person deciding to take their own life, for example, will affect the lives of family and friends. A society that sees this as an option is likely to become one that makes less provision for people in need. As such the society itself becomes poorer.

Great care needs to be taken so that considerations about whether resuscitation may be appropriate are not biased by vested interests of relatives or carers. Just because these people may be becoming physically or financially exhausted, this is no reason for taking decisions that will hasten the death of another person. The morally strong solution

Resuscitation is...

In cardiorespiratory arrest a patient is not breathing, has no heart beat and is unconscious. To avoid permanent damage to vital organs such as the brain it is important to get air in and out of the lungs (ventilation) and start blood moving in the vessels (circulation) within minutes. For each 1 minute delay, the chance of success diminishes by 10%.¹¹

Sometimes a sharp and heavy thump on the centre of the person's chest will literally knock the heart back into action. This occurs when the heart muscle has lost its co-ordinated contraction and is instead quivering gently—a condition called ventricular arrhythmia. The impact of the thump on the chest may restore near normal activity.

If this doesn't work then applying an electric shock across the chest can also jolt the heart back into co-ordinated contraction.

In ventricular fibrillation, the heart no longer pumps effectively, but some circulation can be maintained by applying sharp pressure to the lower breast bone about 80 times a minute—external cardiac massage. This squeezes the heart, and because of the heart's one-way valves, it expels enough blood to enable brain and other organs to survive while other measures are taken to attempt to restore normal cardiac contraction.

Occasionally, in a hospital situation, a doctor may attempt internal cardiac massage by making a hole in the person's chest, reaching in and physically squeezing their heart.

While this is going on it is important to get air into the person's lungs. This can be done either with mouth-to-mouth techniques, using a special mask and hand-held bellows, or by passing a tube through the person's mouth and into his or her trachea.

Sometimes stimulating drugs like adrenaline can be given to the heart, while at other times anaesthetics like lignocaine may be used to calm down arrhythmias. On rare occasions doctors may infuse sodium bicarbonate into the blood stream in an attempt to correct the acidic conditions that are occurring due to the build-up of carbon dioxide inside the body.

is to find additional support for all the people involved in the situation.

Questions of death

Contemporary society is uneasy about death. It is a taboo subject that is seldom discussed. Contemporary medicine can equally be accused of being scared to talk about death and there is a tendency to see death as the ultimate failure. This is strange, as death is the one certainty for all living things.

Christianity is torn between seeing disease and death as outrages against God's creation, and as means of moving towards closer relationships with God. Many Christians join the writer C S Lewis in seeing pain as God's 'megaphone to rouse a deaf world.'¹⁰ Pain, illness and death are seen as inevitable consequences of

humankind's decision to ignore their creator God.

While old age may have its frustrations as health starts to fail, it is not an evil, but rather a stage of life to be respected and honoured.

Death, however, does provide merciful release from life trapped in a damaged and decaying body. Christians believe that life continues after the body ceases to function, with the possibility of spending eternity in peace and in an unimaginably close relationship with the God who created everything.

A call for communication

One explanation for the lack of agreement between doctors and patients about whether a DNR order should be placed in their notes is that the two groups use different

languages. Doctors speak in terms of technology and physical symptoms, and tend to reduce their patient to a biological entity. Patients use a non-technical language that talks of their subjective experience and their place within a network of social relationships. Without care the two parties will never understand each other. Because the patient is unwell, possibly confused and feeling vulnerable, it has to be the physician's task to exercise that care.

There is also the anxiety that once a decision has been made it can not be changed. A large study of heart patients showed that 2 months after initially saying that they wanted resuscitating if possible, 14% had changed their minds. At the same time, 40% of people who initially said that they did not want resuscitation now thought that they did. The current recommendation is that DNR orders are reviewed every 24 hours and that people are given the opportunity to express their opinion if it changes.

Physicians have been encouraged to move away from a paternalistic approach to decision-making where the doctor decides and the patient simply accepts the decision. Instead a system of informed consent is encouraged. In this doctors give information to their patients, but the decision rests with him or her. In reality this is difficult as the person or their relatives may not be in a position to accept this responsibility.

A third option is to encourage dialogue between doctor and patient where both draw on their areas of expertise. The doctor has the medical knowledge and training, and the patient knows what he or she most wants to get out of life. Together they can come to a shared decision. For this the doctor needs to create an open atmosphere in which information can be freely exchanged and will also need to spend more time getting to know the individual patient.

Caring for the weakest

Doctors have the responsibility of caring for their patients. Part of this care is to determine the likelihood of any treatment being appropriate to a person. When it comes to decisions about resuscitation there are various scoring systems that can help a physician draw a conclusion based on the available information. Concluding that attempts at resuscitation are inappropriate can in itself be an action of care.

A DNR decision based on the conclusion that attempts at resuscitation would be futile is very different from one based on 'quality of life' criteria.

Doctors are privileged to meet people at crisis moments in their lives and provide expert assistance. The highest form of inter-personal relationship is one of respect based on the assumption that all involved can be trusted to provide the best for each other.

The key to providing this high standard of trust is that doctors retain the basic attitude of wonder, respect, empathy and protection. The weaker the person, the more these need to be emphasised.

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Further reading

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