

**Michael Webb-Peploe**  
offers a Christian  
Perspective

# Not for Resuscitation?

In a recent British Medical Journal editorial,<sup>1</sup> Professor Shah Ebrahim drew readers' attention to the dossier of over 50 cases assembled by Age Concern England and publicised in the national press where 'not for resuscitation' was posted on the notes of elderly patients without this being discussed with either patient or relatives. An independent review of one of these cases noted: 'It was hard to avoid the conclusion that that the treatment plan... was to do little more than allow the patient's life to ebb away'.<sup>2</sup>

In 1999, The British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing jointly said that 'do not resuscitate' (DNR) orders could be considered only after discussion with the patient or others close to the patient, and that they should be reviewed at regular intervals. It appears that these guidelines are frequently flouted. In one American series,<sup>3</sup> over two thirds of the patients studied were not involved in their own DNR decisions. Even if there is discussion, information given is often not recalled, viewpoints often change as the disease progresses (or regresses), and decisions are poorly understood.<sup>4,5</sup>

What is even more disturbing is that DNR orders result in a greatly reduced quality of medical and nursing care and attention. One study found a greater than thirty-fold increased risk of dying in patients with DNR orders even after adjusting for disease severity, prognostic factors, age and other covariates.<sup>6</sup>

But Cardiopulmonary Resuscitation (CPR) after an in-hospital arrest is effective in only about 20% of patients,<sup>7</sup> and in many cases will have to utilise the scarce resource of an intensive therapy unit (ITU) bed.

In the present day National Health Service, this may deny another patient (perhaps with a better long-term prognosis) their chance of life-prolonging and quality-of-life enhancing treatment such as coronary artery bypass graft surgery. The attempt to resuscitate is sometimes (to use Ebrahim's headline) flogging dead horses, a messy and futile exercise denying the patient a dignified death.

What does the law say? In the United States, the body of law known as right-to-die cases extends ordinary treatment-refusal doctrine to end-of-life decisions.

The courts, having affirmed a right to refuse life-sustaining treatment, could find no rational distinction between competent versus incompetent patients, withholding versus withdrawing treatment, and ordinary versus extraordinary treatment. The courts, however, have persistently affirmed one categorical distinction: between withdrawing life-sustaining treatment



## DOCTORS MAY DETERMINE WHETHER A TREATMENT IS FUTILE, BUT THEY CAN NEVER DETERMINE WHETHER A LIFE IS FUTILE

on the one hand and active euthanasia or physician-assisted suicide on the other. In *Washington v Glucksberg and Vacco v Quill*, the Supreme Court unanimously held that physician-assisted suicide is not a fundamental liberty interest protected by the American Constitution.<sup>8</sup>

New York State Statute governing resuscitative decisions requires that:

1. All persons be presumed to have capacity to make their own treatment decisions, and thus incapacity must be established by written determination of the attending physician; failure to do so is sufficient basis to rescind DNR orders requested by a surrogate.

2. Surrogate decision to request a DNR order must be supported by the patient's current medical condition and fulfil statutory criteria; physicians' opinions regarding hypothetical future conditions without firm evidence of the 'medical futility' of treatment for that patient are inadequate support for a surrogate DNR decision.

3. Statutory provision allowing a surrogate to authorise a DNR order on the basis that resuscitation measures would pose an 'extraordinary burden' for the patient is unconstitutionally vague.<sup>9</sup>

In the United Kingdom, some consider that DNR decisions can legitimately be made without consulting the patient if:

- Morbidity scores indicate that they are unlikely to survive CPR
- They are mentally incompetent.

In one survey of the case notes of elderly medical patients,<sup>10</sup> 30% were predicted not to survive CPR, another 28% were deemed incompetent. Of those with DNR orders, 59% were predicted not to survive CPR, a further 24% were incompetent, and discussion of resuscitation would have been appropriate in 17%. Little mention was made of the family in these discussions.

Mental competence is a very grey area. DNR decisions analysed for 97 admissions to a psychogeriatric ward of a Dutch general teaching hospital showed that at the end of six weeks DNR orders were predictable by the four variables of dementia, use of antidepressants, age and

pre-arrest morbidity index in that order.<sup>11</sup> The association of the use of antidepressants with the presence of a written DNR order is surprising, and raises the strong possibility that an overly pessimistic view of quality-of-life by a depressed patient unduly influenced the DNR decision.

### A Christian Response

Does the Christian faith shed any light on the DNR debate? I believe that it does, and here I must acknowledge my debt to John Wyatt's book *Matters of Life and Death*, and in particular to his chapter ten, 'A better way to die'.<sup>12</sup>

The biblical world view provides us with the following insights:

1. Human beings, even in an agony of suffering, or in a twilight mental state, are God-like beings. And any being made in God's image deserves a range of responses: wonder, respect, empathy, and above all protection from abuse, from harm, from manipulation, and from wilful neglect.

2. In the incarnation, God re-affirmed once and for all the value that he places on humanity, created in his image. Every patient, no matter how deformed the body, deranged the mind, diminished the personality, carries this double hallmark of divine value.

3. Human life is sacrosanct, and there is a strict line drawn between removing suffering and removing the sufferer. Euthanasia (homicide) and suicide (whether physician-assisted or not) are both opposed. The deliberate destruction of a human life (whether by its own hand or by that of another) desecrates God's image.

4. Not only is each individual human life special, but we are all part of the human family, created to be in community. To think that matters of life and death can be decided in isolation, by a single individual, is a dangerous illusion.

5. Death as a consequence of the fall is the 'last enemy',<sup>13</sup> an evil and an outrage to be fought. Similarly, the loss of function, infirmity and the degenerative disease that come with age are real evils. Dylan Thomas expressed this in striking

terms writing of his father's blindness;

*Do not go gentle into that good night  
Rage, rage against the dying of the light.*

Old age itself is not an evil, but rather a stage of life to be respected and honoured. For those trapped in a fallen and decaying body, living a severely limited and frustrating existence, death can come as a merciful release, a sign of God's grace. Christian attitudes to death reflect this strange ambiguity: on one hand it is an evil to be fought; on the other hand it may at times be accepted, even welcomed, as a sign of God's mercy and grace.

6. Pain and suffering are the inevitable consequences of man's rebellion against God, of our turning our backs on obedient communion with our creator. Suffering is a painful and universal reality which we can either accept or reject. If accepted from the hand of a loving God, he can transmute the evil of pain and grief into the good of deeper communion with himself. As CS Lewis wrote:<sup>14</sup> *'The human spirit will not even begin to try to surrender self-will as long as all seems well with it. Now error and sin both have this property, that the deeper they are the less their victim suspects their existence; they are masked evil. Pain is unmasked, unmistakable evil; every man knows something is wrong when he is being hurt....*

*Pain insists upon being attended to. God whispers to us in our pleasures, speaks in our conscience, but shouts in our pains: it is his megaphone to rouse a deaf world.'*

Christianity teaches us to value human beings because of who they are, because of how they have been made, because they are known by God and immensely valued by him, rather than on the basis of what they can do.

Medicine cannot hope to eliminate all suffering and death but must always seek to eliminate unnecessary suffering and untimely death. Quoting Wyatt again:<sup>12</sup> *'The essence of being a good doctor is to know when "enough is enough". But how do we know when we should withdraw treatment, or withhold it? It is when the burdens of any particular medical treatment outweigh its benefits.... There is, however, a fundamental*

*difference between making treatment decisions, and making value-of-life decisions. Doctors are qualified to make treatment decisions: to decide which treatment is worthwhile and which is not. But doctors are no better qualified than anybody else to make value-of-life decisions: to decide which life is worthwhile and which is not. Doctors may determine whether a treatment is futile, but they can never determine whether a life is futile. When we withdraw or withhold treatment, we are expressing a belief that the treatment is valueless, not that the patient is valueless.*

Applying these insights to the DNR debate we can conclude:

1. The doctor has the responsibility of determining the likelihood of success of CPR in the event of an arrest. A variety of 'pre-arrest morbidity' scoring systems exists and can be useful to formalise an assessment of the usefulness or futility of CPR.

2. Value-of-life in any individual patient can only be assessed by discussion with all those concerned: patient, relatives, medical and nursing staff, the patient's spiritual adviser (if known). In the presence of depression or dementia, the patient's views may be unreliable or unobtainable. Surrogate views from relatives may be influenced by the vested interests of physical or

financial exhaustion or by 'carer's burn-out'. But such reservations are no excuse for failure to discuss value-of-life issues, and, in many cases, these issues will need to be revisited and updated at regular intervals. Failure of communication between doctors, patients and relatives lies at the heart of the present furore over DNR orders.

In an editorial entitled: 'How to improve communications between doctors and patients',<sup>15</sup> the authors distinguish three approaches to treatment decision-making:

**Paternalistic.** Doctors using this approach want short descriptions of physical symptoms easily transformed into diagnostic categories which in turn lead to treatment decisions considered by the doctor to be 'in the best interests of the patient', without having to explore each patient's values and concerns.

**Informed (or Consumerist).** The doctor's role is here limited to providing relevant research information about treatment options and their benefits and risks, leaving the patient to make an informed decision.

**Shared.** Doctors commit themselves to an interactive relationship with patients in developing a treatment recommendation that is consistent with

patient values and preferences. For this to happen, the doctor needs to create an open atmosphere in which information exchange helps the doctor understand the patient, and ensures that the patient is informed of treatment options and their risks and benefits. Treatment decisions are made jointly (not solely by a paternalist doctor, nor solely by a consumerist patient), and patients can assess whether they feel they can build a relationship of trust with their doctor.

The highest form of inter-personal (and thus of doctor-patient) relationship is a covenant commitment of respect-love. But as Wyatt points out:<sup>12</sup> *'caring for people with respect does not mean that we are obliged to provide intensive and burdensome medical treatment to prolong life at all costs. As in all other clinical situations, the burdens of any proposed treatment must be weighed against its benefits... Withdrawing or withholding medical treatment is not the same as intentional killing. We retain the basic attitudes of wonder, respect, empathy and protection'*.

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## KEY POINTS

Recent high profile cases and literature reviews confirm that 'not for resuscitation' guidelines are frequently flouted on both sides of the Atlantic. 'DNR' orders have also been shown to affect adversely both attitudes to patients and the standard of care they are given. A Christian response must be based in a biblical worldview that affirms the dignity, worth and interconnectedness of all human beings as being made in God's image. Whilst recognising that pain, suffering and death are, to some extent, inevitable consequences of the Fall we must always seek to eliminate unnecessary suffering and untimely death. Good DNR decisions should be made in partnership with patients and relatives, and be based on evidence-based survival prospects rather than value-of-life assessments.

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