A recent article raised the issue of whether cardiopulmonary resuscitation (CPR) is currently being performed in the most effective manner. According to the article, many of the skills that are carefully taught in CPR classes are neglected in the stress of an actual real-life emergency. Certainly, everyone hopes that an awareness of the problem and new monitoring techniques will improve patient care. There are, however, several other aspects of CPR where ethical concerns are not adequately addressed.

In the context of this discussion, Do Not Resuscitate (DNR) orders are instructions that, in the case of cardiac arrest, CPR is not to be attempted. Although this is a common occurrence in clinical hospital practice, insufficient time and effort is expended in educating health care providers about the ethical issues involved and how these issues impact discussions with the patient and family. On a practical level, there is often a large gap between the physician’s understanding of the likelihood of success and the risks of CPR compared to patient and family expectations. This overview is intended briefly to review some of the important ethical issues involved, and to provide practical information for discussion with patient and family. With facilitated communication, decisions will more closely approximate the ethical ideal of informed consent.

The decision not to perform CPR is most commonly made in a situation where a patient’s condition appears terminal and has deteriorated to a point where death is imminent even with continued therapy. Few physicians would advocate CPR in this situation. If there are no extenuating circumstances such as a request from the patient to maintain life so that some final business can be concluded or family visit accomplished, then there appears to be no ethical problem with allowing the patient to die without attempted resuscitation.

Another situation that frequently occurs is that of a chronically ill or terminally ill patient in which CPR could potentially extend life for an indefinite period, but at a severe cost to the patient in
terms of suffering. This suffering could be either the direct result of CPR or the result of the ongoing disease process. In either case, the issue becomes one of determining whether the burdens of the treatment are commensurate with the possible benefits. The decision is subjective and patients are unique in their assessment. The patient has a very clear task to distinguish between burdensome and beneficial treatment. It is not inconsistent with Christian thought for a patient to decline CPR if they feel the burden outweighs the benefit and life is unlikely to be sustained in a meaningful way. It is at this point that communication between patient and physician is paramount. There is great confusion on the part of the general public regarding the success rate and risks of CPR. For an ethically valid judgment to be made the patient must have accurate information; the physician must explain clearly.

It should not be forgotten that when CPR was developed in the 1960s, it was primarily recommended for previously well individuals who underwent cardiac arrest. Since 25-50% of these patients survived the cardiac arrest if the CPR was begun within 5 minutes and since no discussion had previously taken place with patients, it was assumed that CPR would be welcomed and appropriate, as indeed it generally was. The progressive pattern of viewing CPR as appropriate for a large number of individuals with terminal disease was not surprising but it was unwarranted. Under the tutelage of television medical shows, the public came to view CPR as generally successful and benign. Both impressions are inaccurate.

Various studies have been published and a review of these studies provides a more realistic view. In one analysis, a series of fourteen studies between 1980-1991 were combined with the following overall results. 13.5% of patients who underwent CPR survived to hospital discharge. Survival to discharge (STD) was negatively influenced by several factors. Among all individuals with cancer, the STD was 5.8% and in those with metastatic cancer, the STD was zero. In those patients with only heart disease who experienced a myocardial infarction while in the hospital, the STD was 24%. In two studies on intensive care patients the STD was 11% and 5% respectively. A series of dialysis patients undergoing CPR showed an 8% STD. While some studies were somewhat more encouraging even these studies showed only a 25% STD.

An overview of the previously cited studies shows that many patients who were resuscitated successfully had some combination of fractured ribs, fractured sternum, aspiration pneumonia, and mediastinal hemorrhage. Note also that approximately 10% of patients remained in a persistent vegetative state (irreversible coma). Potential neurologic complications are not restricted to coma. In another series, 155 survivors of CPR were followed up and periodically evaluated by neurologists and neuropsychologists. Three months after CPR, 60% of the patients were noted to have moderate to severe cognitive impairment. At 12 months, 48% still had moderate to severe impairment.

The findings listed above clearly indicate that CPR is neither as successful nor as benign as generally regarded. Survival to discharge is highly dependent on the patient's overall medical condition and the nature of the underlying disease process. Complications from the procedure are significant and merit careful consideration. It is necessary for physicians or other health care workers to carefully inform patients of these facts and ascertain that the information has been processed and understood before we can consider a decision ethically valid.

The last statement begs the question of how and when is it best to have such discussions with
the patient. While this is a matter of clinical judgment, it seems clear that the conversation must take place while the patient is lucid and able to reflect on the information in light of their value system. Including members of the family and other individuals whose opinions the patient values may facilitate this process of reflection. The patient's need for information and support may be best met by a discussion of CPR as part of a longer conversation that includes various possible medical scenarios and treatment options. This discussion should include the physician's assessment of whether he or she believes that CPR is indicated in this particular situation. If the recommendation is against CPR, it is important to emphasize to the patient that this does not mean abandonment. It simply means that in this situation CPR does not seem to be in the patient's best interest. Rather, medical therapy and comfort measures suited to the particular disease will be continued. Differences of opinion between the physician and patient can be reduced by good communication.

It is also important to document carefully the DNR order in the patient's chart and list other appropriate treatment modalities. There are clinical situations in which aggressive medical therapy may be continued including admission to the Intensive Care Unit. For example, an elderly patient with severe coronary atherosclerosis and poor cardiac function may elect to be treated aggressively with medications but not be a candidate for CPR. In other situations, the DNR order may be the initial step in the withdrawal of other treatments in view of the patient's impending death. Clearly, it is necessary to document the overall plan in the chart.

A direct corollary of this careful documentation in the chart is good communications between all members of the health care team. In addition to documentation, the medical rationale and the specific plan should be discussed with the nursing staff so that the patient and family do not receive mixed signals from different members of the team—a not uncommon occurrence in current medical practice where multiple specialists and other providers are involved in patient care.

In conclusion, several potential ethical problems arise in relation to DNR (do not perform CPR) orders. In particular, the importance of adequately informing the patient and family of the potential benefits and complications of CPR in the current medical situation is stressed. The need for good communication, while critically important at the bedside, should extend to other members of the medical and nursing staff. Misunderstandings, which often lead to Ethics Committee consults, can be minimized by communication both verbally and by documentation in the medical record. From a Christian perspective, medicine is seen as a healing art, which includes ?coming along side? patients?and their families?to share in their suffering in this fallen world. Much emphasis must be placed on the emotional availability of physicians to the patient and family through the entire dying process. Whatever our medical limitations, we can work to assure that appropriate loving care continues. Fear of abandonment is one aspect of dying that can be combated and defeated.


2 MH Ebell, ?Prearrest Predictors of Survival Following IN-Hospital Cardiopulmonary


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