Platform

Resuscitation of the terminally ill: a response to Buckman and Senn

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Current CMA procedural guidelines on resuscitative intervention for the terminally ill clearly stipulate that when the clinical assessment of a patient justifies the writing of a "Do not resuscitate" (DNR) order the attending physician should discuss with the competent patient the option of no resuscitation.[1] If the patient is incompetent "the appropriate member(s) of the patient's family should usually be closely involved in the decision-making process".[1]

According to Dr. Ramsay W. Gunton, past president of the Royal College of Physicians and Surgeons of Canada, this approach to DNR orders "is sometimes ethically incorrect".[2] With some patients, Gunton maintained, "it is ethically defensible to write a DNR order without consultation with the patient".[2]

Arguing along similar lines, Buckman and Senn[3] recently challenged the CMA directives on resuscitation of the terminally ill[4] in so far as they apply to "dying" patients, whom Buckman and Senn defined as meeting the following criteria:

- The patient suffers from a diagnosed pathologic condition known to be irreversible and fatal.
- The intention of treatment is palliative and no curative intervention is being carried out or planned.
- The patient is expected to die within a short time [perhaps 90 days[5]].
- The preceding criteria have been confirmed by an independent physician not directly involved in the patient's care.

In their view, patients meeting all these criteria should not be offered cardiopulmonary resuscitation (CPR). Instead, the attending physician should unilaterally write a DNR order.

Underlying this contention is the belief that "the physician is not required to provide therapy contraindicated on medical grounds".[3] To some this may seem an uncontroversial claim, but much turns on the meaning of the phrase "medically contraindicated". If this phrase is narrowly understood to refer to specific treatments that in specific instances are improper or undesirable because they are known to be completely ineffective — as when there is no chance of restoring cardiac output for a given patient by means of CPR — then it is certainly true that the physician is not required to provide such therapy. Consider, for example, patients with a seriously ruptured myocardium, a pulmonary artery completely filled by embolic material or a seriously ruptured abdominal or thoracic aortic aneurysm: for these patients CPR would be contraindicated on medical grounds.[6]

If, however, the phrase "medically contraindicated" refers to treatments that are undesirable from a medical standpoint because their probable effectiveness is low and because it is expected that the resulting quality of life would be unacceptable, then the claim that physicians are not required to offer such therapies is contentious, particularly if there are no alternatives to the therapy in question.

The principle of respect for persons is commonly understood to require that we not interfere with or frustrate the wishes of autonomous individuals (i.e., those who are capable of self-determination), that whenever possible we act in such a way as to promote individual autonomy, and that for persons with diminished autonomy (e.g., children or persons with mental disabilities) we provide protection. It is in order to uphold this principle that physicians are morally obliged to request and obtain the informed consent of patients or their legal guardians before they start or stop medical treatment.

From this it follows that as long as a therapy has some probability of success, any decision about treatment rightly belongs to the competent patient or the incompetent patient's legal guardian, who can weigh the expected benefits and harms and make a choice. As Brett and McCullough[7] rightly insisted, "if a potential medical benefit is present, then the benefits seen from the patient's perspective should modulate the risk–benefit assessment". As such, when there is a modicum of medical benefit (even if short term) it is not for the physician to decide that because a particular treatment is only minimally effective from a medical perspective, it is of "no benefit" and therefore need not be offered.

The benefit–harm ratio of a particular therapy cannot be assessed without consideration of the patient's interests, values and expectations. What appears to the physician to be useless and possibly harmful may be seen as useful and beneficial by

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← For prescribing information see page 1100

the patient or a relative. This is because a seemingly small benefit may be valued very highly by a terminally ill patient with certain beliefs or short-term objectives. Therapy that delays an unavoidable death "for a couple of days or weeks in the intensive care unit — intubated and sedated and with an arterial line, central line, Foley catheter and nasogastric tube in place"[8] may be of "no benefit" from a medical viewpoint, where the litmus test is survival until hospital discharge. From a patient's perspective, however, a week's reprieve may be of great benefit. Consider, for example, a patient who wants to stay alive for a daughter's wedding in a week. Contrary to what some may believe, postponing an imminent and unavoidable death is not by definition harmful.

Tomlinson and Brody[9] wrote most eloquently on this point. They recognized at the outset that there are three distinct rationales for DNR orders: no medical benefit, poor quality of life after CPR and poor quality of life before CPR. They maintained that if the justification for a DNR order is that CPR is medically contraindicated (in the narrow sense described earlier) the decision is one "that falls entirely within the physician's technical expertise". However, when this is not the reason for a DNR order the patient or his or her proxy must be consulted to ascertain what values are relevant to the decision-making process, in which the benefit of continued life will be weighed against such harms as pain, disability and permanent loss of consciousness. According to Tomlinson and Brody,

> Since the physician's values may well differ from those of the patient or the patient's family acting as proxy, and since the patient has both a legal and a moral right to accept or refuse treatment in accordance with his or her values, the values used to make these quality-of-life determinations are properly the patient's.

In contrast, in providing a list of criteria that, if satisfied, would permit the writing of unilateral DNR orders Buckman and Senn[3] failed to distinguish between a life that cannot be saved and a life that, in their opinion, is not worth saving.

To be sure, there is no ethical imperative to do the impossible. If CPR is medically contraindicated because it will be completely ineffective (i.e., it will not restore cardiac output), there is no moral obligation to provide CPR in an attempt to sustain life. The physician could decide on the basis of his or her expertise to write a DNR order. Then he or she would simply inform (and not consult with) the patient or legal guardian about the decision made. In such cases, however, the burden of proof would clearly rest with the physician to show unequivocally that any attempt at resuscitation would be completely ineffective.

Conversely, if there is any chance that CPR may be effective, even if that chance is infinitesimally small and death may be postponed only for a very short time, the decision about resuscitation rightly belongs to the competent patient or the incompetent patient's legal guardian. This is so regardless of whether the patient is receiving only palliative care and is expected to die within a short time.

Buckman and Senn raised an important question: Should physicians have the authority to write DNR orders without consulting patients or their legal guardians in cases in which CPR is contraindicated on medical grounds? However, they went too far in expanding the circle of patients who might be denied the option of consenting to or refusing resuscitation in failing to distinguish between therapy that is truly of no medical benefit and therapy that, although of limited medical benefit, on the whole may be perceived as beneficial from the patient's perspective.

Some patients may want to live an extra few days or weeks, and if CPR can provide them with that chance, in principle they or their legal guardians should be fully informed of the expected limited medical benefits and harms of CPR and offered a choice between CPR and a DNR order. This said, on occasion a patient or legal guardian will choose resuscitation even though the prognosis is extremely poor. Thus, in some cases respecting the patient's or guardian's wishes may seem an indefensible expenditure of scarce medical resources. However, until and unless society makes such microallocation decisions or, alternatively, decides that physicians are entitled, obliged or qualified to make decisions about allocation (as contrasted with medical decisions) at the bedside, the wishes of the competent patient or the incompetent patient's legal guardian, based on an assessment of the benefit–harm ratio, should be respected.

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