Mr. JW was 76 when he died. Six months earlier, I had a long talk with him and his wife when he was leaving the hospital after three weeks on a ventilator for the treatment of pneumonia.

Doctor: As you know, you have severe emphysema and you will need to be on oxygen around the clock.

JW: Yes, I know that. I am hardly able to move. I can’t finish a sentence without getting short of breath.

Doctor: You must stop smoking.

JW: I cannot and I will not. This is the only source of joy for me now. I know it is killing me. But I want you to know that I do not want to be placed on the ventilator again. Next time, please let me go in peace.

Doctor: After all it is your choice. I promise to follow your directive. (His wife nods as if to say “I agree”.)

Four months later, Mr. JW’s wife brought him to the emergency room with chest pain. He was drenched in sweat and suffocating:

Doctor: Do you want me to place you on a ventilator to breathe for you?

JW: Nods, and wife screams “He is dying, do something!”

JW was placed on a full assist ventilation. He had an anterior MI, severe left ventricular systolic dysfunction, anuria, intramural thrombus and an embolic stroke. Despite artificial dialysis and multiple team intensive care, JW died from multiple organ failure and systemic infection six weeks later.

Another patient:

Mr. GH, a 67 year-old homeless person, developed out-of-hospital cardiac arrest. He received bystander cardiopulmonary resuscitation (CPR). In the intensive care unit, he was sustained on the ventilator, developed renal failure requiring dialysis, ARDS, peripheral gangrene requiring toe and finger amputation and systemic infection. He never recovered consciousness, and a Do Not Resuscitate (DNR) order was contemplated two weeks later. An eligible relative (nephew) was found in another state after a few days of searching (otherwise a court appointed guardian would have been needed). The nephew’s instructions were “continue to do everything possible.” He did not give DNR consent. Mr. GH died four weeks later in intensive care.

These two cases represent everyday occurrences in the practice of cardiology and intensive care. Do these cases represent the exercise of patients’ autonomy in the choice of resuscitation? Did they serve the patients’ best interests? In the first case, was a dying patient’s cry for help a plea for resuscitation or relief? In the second case, was the relative’s choice a true representation of the patient’s own choice assuming that he could be fully informed, able to comprehend and had the leisure to make an uncoerced choice?

Cardiopulmonary resuscitation by necessity is undertaken under unusual circumstances. A large percentage of patients who at one time expressed a desire for DNR change their minds when facing the imminence of death (1). One wonders whether this change is based on rational reevaluation of circumstances or is simply reflective of the gravity of the situation. Also, surrogate decisions are often discordant with the patients’ own wishes, tainted with feelings of guilt, fear of loss of a loved one, concern about possible future accusations that they didn’t show enough concern, or motivated by self gain (2,3).

The common practice of “do everything possible” by which interventions are undertaken with no clear health benefit to the patient is neither rational nor humane. The open salad-bar-eat-all-you-can approach to medical care of the dying is wasteful and cannot be sustained. Patients’ families often ask for “do everything possible” out of convenience, and because there are no economic consequences to them.

For physicians, the same attitude safeguards against possible litigation, and in many instances, is rewarding financially. In addition, it satisfies a physician’s passion for high-tech interventions.

Furthermore, for the minority of Americans who execute Advance Directives, the patient’s true wishes about medical care in terminal illness are often neglected, overlooked, overruled, renegotiated or re-interpreted (2,4,5). Such behavior from physicians and the public undermines the patient’s autonomy and complicates an already vexing problem.
Is there a solution to this wasteful, high-technology driven death-denying attitude toward terminal care? Cardiopulmonary resuscitation (CPR) is a medical intervention that must have its indications and therapeutic goal. In our view, it must not be applied unless there is a reasonable hope for a conscious life with a chance that the patient will be able to pursue and achieve some degree of happiness. The prevailing policy of consent DNR (6,7), i.e., resuscitate every patient unless he is clearly terminal in extremis and death is imminent, and provided the patient or surrogate agree to DNR, needs further review. We argue that like other medical treatments, CPR should be the domain of the treating professionals.

Two questions have to be addressed: First, would such policy undermine the patient’s autonomy? Second: Does it give undue power to physicians?

According to the American Constitution, the individual has supreme authority over his body (8). Therefore, any policy that undermines such authority is, unconstitutional. It follows that life and death decisions should be left in the hands of individual or his appointed proxy. On the other hand, the exercise of autonomy requires full information, capacity to evaluate and choose and ability to make a free spontaneous decision. Clearly, these conditions cannot be satisfied in the emergency room or intensive care unit. Furthermore, credible studies have shown that after patient’s death, a large percentage of families report that their loved ones were not treated according to the patient’s expressed wishes (4), and others regret what they allowed their loved ones to endure (9). In addition, the current restrictive policies of DNR fly in the face of the fact that most fully informed seniors do not wish to undergo resuscitation in the event of cardiopulmonary arrest (10,11) when the odds are overwhelmingly against a successful outcome and when the expected survival to discharge is less than 5%.

The slippery slope argument that by relinquishing so much authority to physicians over matters of life and death could lead to abuse should not be a reason to suffocate a sensible discussion of this vital subject. Physicians are trained to deal with disease and death issues. Like an informed jury that adjudicates life or death in criminal cases, the treating physicians and nurses are suited to evaluate which patients are suitable for CPR based on the patient’s functional status and prognosis.

To guard against possible misapplication and to protect against litigation, we propose that national guidelines for CPR be developed. Already many authors have proposed such guidelines (12,13). These guidelines will need to be reviewed and refined by a consortium of medical establishment including the AHA, ACC, AMA and Association of Medical Specialties among others. Furthermore, health care professionals and the public at large should be better educated about the possible outcomes of CPR under various medical scenarios. The literature indicates that both the lay public and health professionals have unrealistic expectations for resuscitation (14,15).

We believe that guidelines for DNR orders recently articulated by the American Heart Association are extremely restrictive (16). They provide an impediment to the use of DNR orders rather than allow for the rational application of CPR. For example, they call for CPR in cases of permanent vegetative state when high brain functions are irretrievably lost. No counterargument is more eloquent than that of Mitchell et al., who in a recent review of vegetative states asked the following rhetorical question: “Why do we persist in the relentless pursuit of . . . treatments to maintain unconscious existence? Will they be treated because of our ethical commitment to their humanity, or because of an ethical paralysis in the face of biotechnical progress?” (17) Also, the AHA recommends that CPR be withheld only when there is absolute certainty about the patient’s imminent death.

Rational CPR indications should not be required to pass the “absolute certainty” standard advocated by the AHA. As in all human endeavors, the “beyond reasonable doubt standard” applied in legal pursuits should be the guiding standard, and the patient’s best interests should be the ultimate arbiter.

It seems fitting to quote Massachusetts Court proceedings from 1978. In the case of Shirley Dinnerstein, the family of an older patient suffering from advanced cerebrovascular and cardiovascular disease requested DNR for their patient:

“Attempts to apply resuscitation for Mrs. Dinnerstein will do nothing to cure or relieve the illness which have brought the patient to the threshold of death—this case presents a question peculiarly within the competence of the medical profession of what measures are appropriate to ease the passing of an irreversibly terminally ill patient—this question is not one for judicial decision, but one for the attending physician, in keeping with the highest traditions of his profession (18).”

Here we are 20 years later, grappling with the same question. It is time to heed this court’s advice. Let us set in motion the process by which patient’s best interests are duly served.

References