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## Editorial

# Deciding not to resuscitate

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In this issue of the journal two American doctors describe some adverse effects on patients of the widespread American medical practice of discussing with the patients concerned any proposed decisions not to resuscitate them in the event of cardiac arrest (1). Such proposals typically arise when the patient's condition is so serious – as for example in advanced cancer – that cardiopulmonary resuscitation (CPR) is thought unlikely to be of overall benefit. With many such patients, argue Drs Schade and Muslin, the psychological pain inflicted by frank discussions about whether or not they would wish to have CPR if their hearts stopped is so great that it outweighs the good of respecting their autonomy by involving them in the decision-making.

The seven cases they outline certainly give food for thought: one patient is clearly severely distressed following such discussion and her acceptance of 'DNR status'; a second fails to recollect the substance of the discussion but recalls it as being in some way a criticism of his, the patient's, unco-operative behaviour; a third declines to give his doctor permission to withhold CPR but tells a psychiatrist that he has indeed given such permission; a fourth, who because of his recurrent episodes of severe anxiety with each deterioration in his disease, is not consulted about CPR, though his relatives are, and dies after a 'relatively calm' final hospital stay, without attempted resuscitation; a fifth has no recollection of the discussion about resuscitation three days afterwards; a sixth, having explicitly accepted that resuscitation would not be appropriate for her and having affirmed the value of the discussion about resuscitation subsequently became 'depressed and frightened about her approaching death' and said that she wished she had not had, and did not want any further, such discussion; and a seventh became confused, 'tangential', changed the subject, became too tired for discussion, and subsequently avoided any contact with the doctor who had raised the subject of resuscitation.

Such cases undoubtedly serve as important warnings. They warn of the great sensitivity of the context of such discussions and of the distress that contemplation of one's own impending death may provoke. They warn of the confusion that such discussion may elicit and/or produce. They warn of the

possibility that those who accept and even welcome such overt discussion may nonetheless subsequently regret their decisions and wish they'd never been informed. And they warn of the need for skill on the part of clinicians in imparting such sensitive information. But none of the case histories seem to compel a conclusion that discussion of possible DNR decisions with the patient should in general be avoided. Instead other tentative conclusions may be drawn.

One undoubtedly painful conclusion is that in some cases – such as patient 6 – a decision made by the patient to discuss her condition explicitly and consider the possible use or withholding of CPR may be subsequently regretted and lead to considerable distress. What follows from that conclusion is of course another matter. Many would argue firmly that entailed in our moral obligation to respect people is an obligation to respect their deliberated choices even when we are sure that those choices will harm them, even when we have evidence that they may come to regret those choices later. However, if discussions of this sort are to be opened up with patients some sort of continuing counselling or brief psychotherapy may be needed to help them come to terms with their situation more effectively. A second conclusion that might be drawn from the case histories is that people have various psychological defence mechanisms that may be activated by bad news, of which the 'forgetting' by patients 2 and 5, the ambiguity of patient 3 and the evasiveness of patient 7 may all be examples. Such defence mechanisms may be seen as somewhat reassuring by caregivers who wish to discuss bad news, if in fact they help people to cope with news that they find too difficult to confront.

Perhaps the most important conclusion to be drawn from the authors' paper is that *some* patients may not wish to have frank and explicit discussions about whether or not to use CPR if their hearts stop and would prefer not to think about their own mortality. For such patients it is surely not to *respect* their autonomy if a doctor insists that they nonetheless must discuss the proposed withholding of CPR, but rather to override their autonomy. As Drs Schade and Muslin state, the doctor has a duty 'to ascertain whether the patient wishes to enter into such a discussion'. The main problem here, however, is how to identify

patients who don't without actually undertaking the explicit discussions they wish to avoid – a problem that seems to be pointed up by the case of patient 1.

Various strategies are available of which oblique approaches to the issue, with an invitation to ask questions, is the most common. A second type of approach is to ask patients what sorts of interventions they are prepared to *permit* the doctor to undertake, on the grounds that different patients have very different views about the various more or less objectionable therapeutic methods available for the attempted control of serious disease. Some people, for example, (it might be pointed out) have strong objections to the use of chemotherapy; some to mastectomy; some to the use of blood transfusions; some to cardiopulmonary resuscitation with its electric shocks, intravenous drips and possible use of a respirator. If the patient has any such objections or wishes to discuss the issues further, he or she is welcome to do so.

A third possible approach is to ask patients well in advance what they think about such issues (and it would surely be less helpful and more threatening to the patient if such questions were limited to the issue of CPR) and how they would wish their doctors to respond in a variety of hypothetical situations. Would they want to be involved in important but possibly painful decision-making or would they prefer to leave such decisions to their doctors? Would they wish to be told bad news if it arose or would they prefer not to know? Would they wish bad news to be divulged by their doctors to their relatives and if so, to which relatives? And so on. Drs Schade and Muslin dismiss this sort of approach, at least in the limited context of CPR, rather swiftly. 'For instance when a patient is first informed of the diagnosis of malignant disease, it is often of principal importance to the physician to encourage hope that life may go on for long periods of time even in the presence of malignant disease. It is difficult to introduce a do not resuscitate discussion in talking to a patient when the physician is trying to encourage hope and assurance of support' – and they add that in some cases the doctor may consider a DNR decision inappropriate early on, if it might 'deny the patient months of satisfying life'.

There are two separate issues here, worth teasing

apart. The first is the question of whether the doctor's desire to encourage hope should be allowed to override a patient's desire to consider his true situation and alternative ways of dealing with it – in those cases where a patient has such a desire. Most would argue – including perhaps the authors – that where patients deliberately wish to be put in the picture and take an active role in decision-making about their care then their doctors should respect such wishes. And in passing it is worth noting that hope can often be maintained even when confronting the most dismal of prognoses, for given the probabilistic nature of medical prognostication there is in fact almost always available *some* degree of hope, even in the most unpromising circumstances for there is almost always *some* possibility that matters will improve.

The second issue to confront is what to do when the question concerns not the withholding by the doctor of possible CPR which he considers useless, but rather the possible withholding by the patient of permission for the doctor to administer CPR, in cases where the doctor believes that CPR would be beneficial. Here the issue seems clear-cut – doctors simply have no moral (or in many jurisdictions legal) right to impose any treatment upon patients against their will, assuming that the patients' refusal has been competently made (and excluding cases where legislation to protect others is involved).

Given that some patients are likely to want to participate fully in decisions about their medical care while others are likely to wish to leave matters to their doctors, it is important to find out what any individual patient would wish. The question of how best to find out the particular views of patients about these and other sensitive medico-moral issues in ways that serve both to respect them and to benefit them with minimal harm remains wide open. It is an area where empirical research, carried out in the context of the relevant ethical issues and sensitively and professionally performed, may prove to be of immense value.

## References

- (1) Schade SG, Muslin H. Do not resuscitate decisions: discussions with patients. *Journal of medical ethics*. 1989; 15:186–190.