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## Editorial

# Resuscitation policies – action required

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In Britain the Health Service Commissioner – or health ombudsman – has upheld a complaint from a relative that he was not consulted about a hospital decision that his elderly mother, admitted with bronchopneumonia, should not be resuscitated (1). As a direct result the Government's Chief Medical Officer (CMO) wrote to all hospital consultants asking them to consider the implications of the ombudsman's report for their professional practice, 'particularly in respect of the training of junior staff', sending similar requests to the presidents of the Royal Colleges and the General Medical Council. The central request was that consultants should ensure that their policy on resuscitation and its withholding, 'whether it is written or not, is understood by all staff who may be involved, and in particular junior medical staff' (2). The ombudsman himself had 'noted with approval' that the district health authority involved in the original complaint had subsequently produced a written policy and indicated his surprise 'that a written policy on such a difficult and sensitive issue was viewed as something of a novelty' (1).

Earlier this year an editorial in the *Journal of the Royal College of Physicians of London* (JRCPL), noting with sympathy the 'humane' traditional British view that 'sound unhurried clinical judgement, sympathy, understanding and mutual trust rather than abstract principles and printed policy statements have in general stood patients in good stead', nonetheless castigated it as 'indefensibly paternalistic' (3). But, the editorial continued, the American alternative, mandating cardiopulmonary resuscitation (CPR) unless a Do Not Resuscitate (DNR) order has been authorised by patient or family and then written, is less humane – and medicine is a humane and moral enterprise. Moreover the pursuit of written DNR orders does not necessarily achieve its primary purpose of enhancing patient autonomy – on the contrary it can all too easily degenerate into a 'charade' of signing a valueless 'consent form'.

Despite its difficulties, the issue has surely to be addressed. The health ombudsman and CMO make quite clear that it is no longer acceptable to sweep it under the carpet, leaving *ad hoc* decisions to be made by whoever happens to be faced by sufficient pressure or curiosity to do so. In addressing it consideration of

some of medicine's recurrent medico-moral themes is relevant. Thus, given that the central moral objective of medicine continues to be to provide net medical benefit for the patient at the cost of minimal harm, CPR should not be used where this objective cannot be attained. And the less likely it is to be attained, the more clearly positive should be the justification for instituting it. Why? Because CPR is a violent, damaging, painful, alarming and undignified intervention that can be justified *only* by sufficient benefit to the patient – and it is widely accepted that assessments of benefit should be discounted by their probability of occurrence. In this context the JRCPL editorial has some helpful advice and references on the probability of successful outcomes of CPR in different clinical conditions.

But of course assessments of benefit – and of harm – are at least in part necessarily – and notoriously – subjective. Just as the harm of a mastectomy can only partially be captured in the objective description 'excision of breast', and must be further qualified in terms of the subject's own perception of the harm involved (and similarly the anticipated benefits), so too can the harms and benefits of CPR only partially be captured in 'objective' accounts; for a proper assessment, the latter must be amplified by the subject's own perception of the relevant harms and benefits anticipated. Thus even if doctors are only concerned with the traditional Hippocratic moral objective of providing their patients with net medical benefit at the cost of minimal harm, still they will need to respect patients' perceptions about what for them constitute the relevant harms and benefits, and their perceptions of their relative importance. For one person staying alive a little longer may be of crucial importance, and well worth all sorts of harmful interventions to try to achieve. For another, life may be perceived as reaching a natural end whose prolongation is not desirable at all, or only desirable with minimally uncomfortable interventions.

The clinician who wishes to respect a patient's views on such matters is more likely to do so if those views are known! Thus whether or not the clinician is interested in the 'abstract principle' of respect for autonomy (or indeed of beneficence and non-maleficence) if he or she is interested in the 'common sense' medical objective of

benefiting the patient with minimal harm, some way of ascertaining the patient's adequately informed views must be sought. In this context asking the patient directly (but in a way that is kind, tactful and respectful of his or her potential preference *not* to answer such questions) is clearly optimal but often impractical. Alternative options that may be worth exploration in pilot trials include a questionnaire on, or prior to, admission to hospital, asking patients about a variety of issues concerning their attitudes to moral issues that might conceivably arise in the context of medical care. But if the questionnaire is really to respect the patient's perceptions of harm and benefit, it must be designed to allow the patient the option of rejecting such intrusion into potentially painful or worrying areas of concern, and of requesting and authorising the doctor to make such decisions as the doctor thinks best. Respecting such choices – however 'old fashioned' this may appear to some – is just as morally important as respecting patients' choices to participate in the decision-making.

A further move towards such 'patient empowerment' would be to ask them for a designated 'proxy' or 'surrogate' who could be consulted if the need arose. Quite often – but by no means always – this would be the 'next of kin' already asked for on entry to hospital; but some patients might not designate their 'kin' at all for this purpose. In this context the latest British Medical Association statement on advance directives (4) and their potential relevance to medical decision-making is a helpful and welcome advance on their previous rather more negative stance towards advance directives.

Where no such information about the patient's preferences or preferred proxies is available or obtainable then the next norm is to ask 'the family', seeking those members who can best reflect the patient's own views – the so-called substituted-judgement criterion. If no one in the family or otherwise knows what the patient would have chosen then, if the patient is no longer able to be consulted, a decision on the basis of the patient's best interests as perceived by the doctor in the light of all the available information, including that provided by family and friends, is appropriate.

Can a patient or surrogate properly *demand* that CPR be used if the occasion arises? One category of cases where this is not the case has already been indicated – notably where there is no possibility of benefiting the patient; ie where the attempt at CPR would be futile. The obvious limiting case here is where the patient is actually dead. An *almost* equally obvious case is where the patient is in a permanent vegetative state (PVS); few if any clinicians, at least on this side of the Atlantic, would carry out CPR – even if they knew that the patient and or his surrogates had requested or demanded it – if the patient was in PVS. Their rationale would presumably be (a) that the Hippocratic objective – net medical benefit with least harm – could not be attained, since a patient in PVS is incapable of

being benefited; and (b) that in the context of limited medical resources it would be unjust (unfair) to use up those resources on CPR for someone in PVS at the opportunity-cost of other patients who *could* benefit from the use of those resources.

This second line of justification appeals to the fourth of the increasingly widely accepted quartet of *prima facie* moral principles relevant to medical ethics, notably the principle of justice – the requirement to be fair, whether in the distribution of scarce resources (distributive justice), in respect for people's rights (rights-based justice), or in respect for morally acceptable laws (legal justice). These concerns of justice are perhaps the least familiar to traditional medical ethics, which has always and properly been concerned primarily with the patient under consideration. A moment's reflection however will show that doctors have always been concerned with justice in their practice, whether in terms of deciding how fairly to allocate their own personal time and resources amongst their patients and putative patients, or in deciding how fairly to respect their patient's acknowledged rights (for example to health care, or to reject treatment), or how fairly to reconcile their own moral perspectives with the claims made upon them by the law. All three aspects of justice are potentially relevant to a policy on CPR.

Finally it is important to remember that it is not only doctors and their patients who are involved in CPR – so too are nurses. In determining a policy which requires morally laden actions or inactions from nurses their considered views ought also to be obtained, both at ward and at hospital level. Perhaps too, discussion between the various colleges potentially involved, including the Royal College of Nursing (RCN), would be helpful. Certainly the RCN has recently made its own views on DNR explicit. 'Nurses are fully accountable for their actions and cannot shelter behind the instructions of senior nurses or medical staff'; they should be 'fully involved in discussing such a decision with all the other members of the health-care staff, the patient and the next of kin' (5).

## References

- (1) Communications surrounding a decision not to resuscitate a patient – W258/89-90. In: *Report of the Health Service Commissioner*, 1990/1991.
- (2) Letter from the Chief Medical Officer to all consultants on resuscitation policy, dated 20.12.1991. Department of Health reference PL/CMO (91) 22.
- (3) Saunders J. Who's for CPR? [editorial]. *Journal of the Royal College of Physicians of London* 1992; 26: 254–257.
- (4) British Medical Association. *Statement on advance directives*, May 1992. Available from the Medical Ethics Committee Secretariat, Professional and Scientific Division, BMA House, Tavistock Square, London WC1H 9JP.
- (5) Royal College of Nursing. *Resuscitation: right or wrong?* London: Royal College of Nursing, 1992.