

Virtual Mentor

American Medical Association Journal of Ethics
March 2007, Volume 9, Number 3: 174-181.

Clinical case

An ER decision to withhold CPR

Commentary by Catherine A. Marco, MD, and Raquel M. Schears, MD, MPH

Mr. Gold had been complaining of chest pain and shortness of breath, so his family insisted that he go to the ER. As they were driving him over, Mr. Gold became unconscious and remained so until the family reached the hospital—nearly four minutes. Dr. McDonald and his team met the family at the door, placed Mr. Gold on a gurney and rushed him into the ER. As they wheeled Mr. Gold through, his wife demanded that a physician perform CPR to save her husband's life. The couple's two teenage children tried to comfort their mother by telling her their dad was going to be all right, based on what they had seen on hospital television shows about CPR and its promising success rate.

Once in the exam room Dr. McDonald glanced at the patient notes. He learned that Mr. Gold was in his early fifties and in generally good physical condition. Unfortunately Mr. Gold had lost alertness and slipped into a coma on his way to the hospital; his skin was pale and he was severely hypotensive. Dr. McDonald quickly determined that the patient was in progressive cardiogenic shock and was going to die. He knew the family expected CPR, but based on his diagnosis and expertise Dr. McDonald decided that CPR would be futile and did not attempt resuscitation.

Aware that he had to present difficult news to the family, Dr. McDonald knew that he would be confronted about his decision not to attempt resuscitation. Mr. Gold was a relatively young man, in good shape and with a loving family. Given those circumstances, Dr. McDonald figured the family would think he had given up on their husband and father prematurely. He began to second-guess his decision, thinking that, had he tried, he could at least have brought some comfort to the family.

Once alone with the family, Dr. McDonald tried to avoid the topic of CPR. He told the family, "We did the best we could, but he did not make it." The family, clearly heartbroken, asked, "We've seen CPR work before, why didn't it work this time?" Dr. McDonald had to decide what and how much to tell the family. He knew that explaining the true nature of CPR would be a lengthy conversation, and with the news of the sudden death of a loved one so fresh, it would probably provide no true relief.

Commentary

Variations of this case are commonly seen in Emergency Departments (EDs). Patients, families and friends often have unrealistic expectations of resuscitative

efforts, based on a number of erroneous sources of information, including television, movies, newspapers and word of mouth. Education about realistic expectations and appropriate management of emergent cases with unrealistic likelihood of a positive outcome is a challenge, particularly in the ED setting where there is no pre-existing patient-physician relationship, communication and rapport must be rapidly established, and decisions must be made expeditiously, often without the luxury of complete medical history.

Cardiopulmonary resuscitation (CPR) is frequently performed in the ED. An estimated one-quarter million to half a million patients are victims of sudden cardiac death annually in the United States [1, 2]. In many cases, CPR is judged to have a reasonable likelihood of improving outcome. In other cases, however, resuscitation attempts are unlikely to result in beneficial outcomes and may in fact conflict with the values and treatment goals of the patient and family. Understanding the latest research findings in addition to the moral and ethical issues related to resuscitation is essential in deciding on appropriate interventions near the end of life.

CPR is typically performed with the goal of restoring life and health to the patient. In many cases, it may serve other functions, such as bringing a sense of closure to the family by allowing them to be present during resuscitation attempts and bid farewell to loved ones. And it may alleviate guilt for the survivors. But the potential risks of resuscitative efforts must also be considered. These include extensive financial and resource investments—at times to the detriment of other ED patients—resuscitation to a suboptimal quality of life, further injury to the patient, physical disfigurement and financial burdens to the surviving family.

In many circumstances, emergency physicians attempt cardiopulmonary resuscitation for most patients who present with cardiac arrest, unless a legal advance directive specifically stating that CPR not be performed is available [3, 4]. Only a small percentage of people have completed an advance directive, and, of those, even fewer have the document readily available. Because of the lack of functional advance directives available in the ED, the default operative position for many physicians is to attempt resuscitation.

Patient knowledge regarding resuscitation: influence of the media and other resources

Even in this era of rapidly expanding technology and pharmacology for resuscitative efforts, the public's knowledge about resuscitation and its expected outcome is woefully inadequate and inaccurate. Many lay people believe that the success rate of cardiopulmonary resuscitation is between 40 and 60 percent [5-7], but success rates reported in the medical literature are between 0 and 16 percent [8-11].

The reasons for the misinformation regarding resuscitation is not definitively known. The impact of the media's unrealistic portrayals of successful resuscitations has been implicated as one possible source [7, 12, 13]. One study demonstrated an association between high medical drama viewing rates and unrealistically high estimates of

survival [14]. Other forms of influential information include movies, magazines, books and newspapers, patient-physician communication, personal experience, and word of mouth, but the relative contributions of these possible sources is unknown.

Several studies have demonstrated that patient preferences are influenced by accurate data about probability of survival [15, 16]. Just as the media can have untoward effects in providing inaccurate information in the name of entertainment, it can also provide accurate information. A recent study demonstrated that educational videos and material can effectively improve patient knowledge about resuscitation and can affect personal resuscitation preferences [15, 17].

The importance of advance directives

Advance directive refers to any proactive document stating the patient's treatment preferences and wishes in the event that he or she is unable to state those wishes at some future time. The *living will* is a document that often stipulates what type of life-sustaining treatment a person wants initiated, withheld or withdrawn in the event that meaningful recovery is unlikely. The *durable power of attorney for health care* is a document that designates a surrogate decision maker for cases in which the patient is unable to make medical decisions. Most states have out-of-hospital do-not-resuscitate protocols in place [18]. The most important function of advance directives is to facilitate the implementation of the patient's wishes.

While advance directives are an excellent source of information to aid in decision making, there are, unfortunately, several barriers to their widespread use. The greatest barrier, as noted above, is that so few people have completed advance directives [19, 20], and an even smaller minority have the necessary documentation when they arrive at the ED [20, 21]. But even in cases where advance directives are available, there is often significant disagreement among physicians about the role of specific interventions for individual patients, and several studies have demonstrated variable physician compliance with advance directives [22, 23]. Reasons for uneven compliance are unclear. According to one study, most emergency physicians (78 percent) said they would withhold resuscitation attempts for patients with a legal advance directive [9]. Similarly, most prehospital health care personnel (89 percent) stated that they withhold resuscitation attempts for a patient with a legal advance directive [24]. These results suggest that advance directives may be of particular importance to emergency health care personnel.

Individuals' personal preferences about CPR depend on a variety of factors, including age, state of health and clinical setting [25-28]. Recent research has demonstrated that some trends among opinions about resuscitation exist [29, 30]. Bridging the gap between patient preferences and the formal expression of those preferences presents a challenge to health care professionals.

Case discussion

Ethical dilemmas are often due to inadequate or ineffective communication between physician, patient and family. The risk of ineffective communication is intensified in

the ED because those involved rarely have existing patient-physician relationships and there is often too little time to establish them.

Physicians are not obligated to provide treatment which they judge to be of no realistic benefit to the patient. The American Medical Association's *Code of Medical Ethics* states that "Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients" [31]. The policies of other national organizations provide similar guidance. For example, The American College of Emergency Physicians' policy statements indicate that "physicians are under no ethical obligation to render treatments that they judge have no realistic likelihood of medical benefit to the patient" [32]. The situational context assumes these decisions are unbiased, based on available scientific evidence, societal and professional standards, and sensitive to differences of opinion regarding the value of medical intervention in various situations [32].

When interventions or therapies are withheld, the physician should continue to care for the patient with compassion, communicate appropriately and provide information to counsel the patient and family, and coordinate other services that may be helpful. These honest and personalized communications may, in fact, be of greater value than aggressive technologic interventions.

If Mr. Gold had completed an advance directive, Dr. McDonald's ability to honor his patient's explicit wishes could have been facilitated. But no known advance directive existed. Appropriately, Dr. McDonald made a decision to withhold CPR because, in his clinical judgment, it would not have benefited the patient. It is necessary to tell Mr. Gold's family the general circumstances surrounding his death despite appropriate ED care. If the family requests additional information, details about the extent of resuscitative efforts (or lack thereof) are in order. If the family requests even more details, the physician may educate them further about the care provided.

Although details of the case are not available, we presume that Dr. McDonald conducted a thorough evaluation and arrived at an unbiased judgment based on expected outcomes. Communicating with the family on the topic of individual casualty is a delicate matter that must be handled gently. For example, the heartbroken family's question of "Why didn't it (CPR) work this time?" is not well aligned with the impersonal nature of scientific cause and effect. That physicians insulate themselves with the concreteness of numbers, but have little to say when the evidence basis does not link to the particular ultimate outcome, is telling. Saying, "It just happens" or "He came to our attention too late" are equally bleak and inadvisable. For suffering individuals, the random injustice of the universe has little appeal [33]. Without answers, "How is it possible?" becomes, "Why has this happened?" as the suffering look for meaning and final purpose. The latter question remains not a request for scientific information nor a question of what singles out someone for a grim outcome, but a question of ultimate purpose. Penetrating teleological questions make physicians uncomfortable, and the time pressures of the

ED may make avoidance of straight answers and suffering easier, but unethical nonetheless.

Effective communication with grieving families is of primary importance in circumstances such as this case. Focusing on the needs of the family carries greater significance than debating the scientific evidence of medical decisions. Numerous authors have offered communication techniques that may be effective, among them spending adequate time with the family, communicating in a private, quiet location, using active listening techniques and appropriate and understandable language, discussing options available to the family, allowing unrestricted visits, and providing ancillary support resources, such as nursing, pastoral care and social services [34-37].

Using the Three Wishes approach, physicians can tell the surviving loved ones [38]:

- “I wish things were different.”
- “I wish we could comfort you more in this time of tragedy.” Having clergy accompany physicians and sponsor interactions is highly worth the time investment to arrange.
- “I hope an autopsy will provide further answers and restore some order.”

Although it may be difficult, it helps in the long run if the physician can give the family a business card, so they have a resource to turn back to if medical questions arise regarding the ED death of a loved one.

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Catherine A. Marco, MD, is a clinical professor at the University of Toledo and attending physician at St. Vincent Mercy Medical Center in Toledo, Ohio. She is the president of the Ohio Chapter of the American College of Emergency Physicians (ACEP) and has served on the ACEP Ethics Committee since 1997, chairing it from 2001-2004.

Raquel M. Schears, MD, MPH, is a Mayo Clinic staff physician and works in Rochester, Minnesota, as an emergency medicine clinician. She has career interests in contemporary bioethics and the intersection of public health duty and medical service expectations in an urgent setting.

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