Time to Revise the Approach to Determining Cardiopulmonary Resuscitation Status

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IN US HOSPITALS, CARDIOPULMONARY RESUSCITATION (CPR) is the de facto default option—patients must "opt out" by requesting or consenting to a do-not-attempt-resuscitation order. Despite its worthy intent, requiring all patients or their surrogates to consent to a do-not-attempt-resuscitation order to avoid CPR has resulted in an ethically unjustifiable practice that exposes many patients to substantial harms.

Whenever there is a plausible risk of cardiac arrest, the standard approach is to ask patients or their surrogates about their preferences regarding CPR. However, the very act of asking can suggest to the patient and family that CPR may be beneficial, even when the clinician believes otherwise. Additionally, research in cognitive psychology has revealed that default options are often interpreted as recommendations or guidelines, or as the path of least resistance, and that such default options significantly affect decision making.[1] For these reasons, patients or their surrogates may be biased toward choosing full resuscitation status, even when CPR likely would bring little or no benefit and would risk considerable harm. Therefore, the standard approach of neutrally seeking consent to withhold CPR may inadvertently diminish patients' and families' comprehension of the clinical situation and lead to decisions that are grounded neither in patients' values[2] nor in their best interest.

Instead of assuming that CPR must always be offered, we suggest 3 distinct approaches based on the likelihood and degree of potential benefits and harms of resuscitation. In all 3 approaches, physicians must take the time to fully explain the patient's prognosis and likely disease trajectory, clarify any misconceptions, and elicit the patient's values and goals, which should form the basis for all CPR discussions. However, the options offered by the physician should change as the likely proportion of burdens to benefits increases.

Approach 1: Consider CPR as a Plausible Option

Physicians should discuss CPR as a plausible option when the relative benefits and harms of CPR are uncertain, as is often the case in patients whose chronic illness has not reached end stage. Fried et al[3] have shown that patient preferences for treatment are determined by their attitudes toward the burden of treatment and the likelihood of those possible outcomes. Thus, physicians should explore the patient's or surrogate's understanding of the disease, clarify any misconceptions, and discuss the likelihood of successful CPR (approximately 16% of hospitalized patients survive to discharge following CPR)[4] and possible harms of attempting CPR (eg, injury related to resuscitation efforts, prolonged stay in an intensive care unit, disability, anoxic brain injury, or nursing home placement). Physicians should seek a nuanced understanding of the patient's values and expect that patients in medically similar circumstances may choose differently. The discussion, the resulting resuscitation preferences and status, and the patient's values and goals should be recorded in the medical record.

See also p 915.

Approach 2: Recommend Against CPR

Physicians should recommend against CPR when there is a low likelihood of benefit from CPR and a high likelihood of harm, such as when patients have advanced incurable cancer, advanced dementia, or end-stage liver disease.[4] Patients in this category who survive resuscitation are likely to spend their last hours or days in an intensive care unit or have an anoxic brain injury. The physician should approach such patients or their surrogates with a presumption against providing CPR but also remain attentive when discussing the patient's values and goals for unique personal, familial, religious, or cultural factors that might make an attempt at CPR unusually beneficial.

For most of these high-risk patients, physicians should recommend against CPR and explain that they do not want to expose the patient to a procedure that is unlikely to be beneficial and will most likely cause significant harm. Assent to this recommendation by a patient or surrogate would then allow the physician to write a do-not-attempt-resuscitation order. Physicians must be careful not to give

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the impression that withholding CPR means giving up (ie, that other treatments will not be provided) or that the patient will be ignored or abandoned. On the contrary, physicians should explain that their intent is to protect the patient and ensure the best possible experience in the final phase of life.

Despite such a recommendation, some patients in this category or their surrogates may request that CPR be attempted for a variety of reasons, including religious or cultural beliefs. It is ethically acceptable for the physician to acquiesce to such a request as long as it is grounded in the patient's values and goals and there is a potential for a modicum of medical benefit.[5]

Approach 3: Do Not Offer CPR

Physicians should not offer CPR to the patient who will die imminently or has no chance of surviving CPR to the point of leaving the hospital. Once this determination is made, and absent extraordinary but reasonable patient values or goals that might make the harms of CPR in this situation worth risking, it is, in our opinion, not only ethical, but also imperative, that CPR not be offered. The physician's primary responsibility is to protect the patient from unnecessary harm. Indeed, CPR was not intended to be used in this clinical situation.[6]

Not offering CPR for imminently dying patients should be explicitly permitted by hospital policy. However, the decision not to offer CPR should be disclosed to the patient or surrogate. As in the previous approach, physicians should not give the impression that not attempting CPR means giving up or that the patient will be ignored or abandoned, but rather that the intent is to protect the patient from harm and maximize comfort.

If a patient or surrogate continues to insist that CPR be attempted, an ethics consultation should be requested if available. If the ethics consultants concur that the case falls within this clinical situation, and absent highly unusual patient values or goals, the consultants should gently and respectfully inform the patient or surrogate of their support for the decision to not attempt CPR and enter a note to this effect in the medical record. Support from a social worker, chaplain, or patient advocate should be made available to the patient and family as appropriate.

Conclusions

Whenever there is a reasonable chance that the benefits of CPR might outweigh its harms, CPR should be the default option. However, in imminently dying patients, a default status of full resuscitation is not justifiable. Not only is CPR in this situation likely to harm patients without compensatory benefit, the default framework likely influences patients and surrogates to request that full resuscitation is attempted even when the physician believes doing so may be inappropriate. The default option in this situation should be an order to not attempt CPR, perhaps coupled with consultation by a palliative care specialist. Similar reasoning may have motivated 15% of nursing homes in Wisconsin to develop policies that make withholding CPR the default option and to offer full-code status only on an opt-in basis.[7]

Physicians are responsible for recommending the medical means to honor their patients' values and for helping them to identify and achieve their health care goals. This responsibility becomes crucial in the setting of life-threatening illness, in which patients are especially vulnerable and may be exposed to potentially harmful life-sustaining interventions. While promotion of patient autonomy is a fundamental responsibility of physicians, protecting the patient from harm becomes increasingly important as the patient becomes more vulnerable. Sometimes, it should be preeminent.

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