**Resuscitation**

The use of ‘do not resuscitate’ orders is widespread in UK hospitals but until recently there has been no formal policy for this practice. This is now changing with increasing public as well as professional interest in ‘do not resuscitate’ policies.

The moral aims of medical intervention have been defined according to several principles: beneficence, to do no net good, non-maleficence, to do no harm, respect for the patient's autonomy, and justice. Cardiopulmonary resuscitation should only be used if there is a net benefit to the patient as it can be a traumatic and undignified intervention. In many cases the assessment of benefit over harm requires the patient's own view. Respect for patients' autonomy implies informed consent for any treatment decision, including cardiopulmonary resuscitation. This does not apply if cardiopulmonary resuscitation is thought to be medically futile or if the patient does not want to be involved in the decision. If cardiopulmonary resuscitation is thought not to be beneficial, then doctors do not have to offer it. Only 6–15% of patients leave hospital after a cardiac arrest. However, the definition of futility is dependent on value judgements, for instance, if a patient wants to live a further few hours to be able to see a relative. While some ethicists believe that patients should always be offered cardiopulmonary resuscitation, a less extreme view allows doctors to make a judgement on the medical benefit, but not to make quality of life decisions without involving the patient. Generally, research shows that patients would like more communication with their doctors on cardiopulmonary resuscitation and doctors are not very good at guessing the patients’ preferences. The ethics for mentally incompetent patients are particularly complex. A surrogate’s view may be sought on what they felt the patient would have wanted. This is the principle of substituted judgement. The principle of justice implies that all patients have an equal right to be treated fairly with a fair distribution of medical resources. Resuscitating a patient in a persistent vegetative state would go against the principle of justice as well as being of doubtful benefit. The basis for ‘do not resuscitate’ orders falls into three categories: (a) cardiopulmonary resuscitation is of no medical benefit, (b) the current quality of life is poor, and (c) the quality of life after cardiopulmonary resuscitation is likely to be poor. The latter classification takes into account futility, patient consent, and quality of life judgements.

‘Do not resuscitate’ policies are in use in over half of US hospitals with patient or family consent and a written record being made. In 1987 New York became the first state to enact legislation for withholding cardiopulmonary resuscitation. If the patient has not consented to a ‘do not resuscitate’ order, they are presumed to consent to cardiopulmonary resuscitation. In the UK, patient or family involvement is not common practice with ‘do not resuscitate’ orders but recent events have contributed to the production of both local hospital-based and national body ‘do not resuscitate’ guidelines. In December 1991 the Chief Medical Officer wrote to all consultants in England stating that consultants have a responsibility to ensure that their ‘do not resuscitate’ policy is understood by all staff who may be involved, particularly junior medical staff. This was following a complaint made to the Health Service Commissioner concerning a ‘do not resuscitate’ order having been made without consultation with the patient and relatives and failure of communication between the consultant in charge and the junior members of the team.

**Living wills**

It is generally agreed to be medically and morally appropriate to limit treatment to relieving suffering and promoting comfort when a competent patient refuses treatment and/or when the burdens to a patient of treatment will clearly outweigh any benefits. The view that life is good whatever the patient's circumstances is however held by orthodox Jews and some Christians. The British Medical Association has cautiously approved the introduction of advance directives in the UK in a statement in May 1992. In addition, the High Court has recently ruled that advance directives by mentally competent patients about future treatment are legally binding on doctors. This was following a landmark judgement on a schizophrenic patient in Broadmoor Hospital who had banned doctors from amputating his dangerous right leg now or in the future.

The 1991 Patient Self Determination Act in the US requires all hospitals, nursing homes and home health agencies to advise patients of their rights to accept or refuse medical care and to execute an advance directive. This is usually a written instructive directive for end-of-life care, ie, a living will and/or the appointment of an informed proxy whose opinion could help interpret what a patient's wishes might have been in the light of his or her present condition and its possible treatment. In some states in the US the physician is statutorily required to identify a surrogate decision-maker. Physicians, patients and their families generally welcome such directives because of informed consent, increased patient autonomy and reduction of legal liability for actions carried with avoidance of court decisions on incapacitated patients such as those in a persistent vegetative state. However, in the US there is a wide disparity between the number of people who would not wish life-prolonging treatments and the number who have executed an advance directive. Patients may feel that the signing of such a document may be an admission to giving up or that they are going to die soon or that they will receive less treatment than they desire. It is also difficult for the patient to make advance judgements on complex medical procedures and potential quality of life, which can also change with time and state. A recent study has demonstrated that patients change their minds on their wish to be resuscitated. Eight patients out of a total of 100 interviewed following acute admission to a geriatric ward did not wish to be resuscitated. However, three changed their minds to wishing to be resuscitated following recovery. Schneiderman et al have, however, shown that execution of advance directives by patients with life-threatening illness did not affect the patient's well-being or health status. The decision on whether to administer life-prolonging treatment in the increasingly elderly population is becoming more important.
Euthanasia

A recent well-reported case has stimulated debate on euthanasia and a recent British Medical Journal editorial proposes the need for a royal commission to examine this issue. A referendum was put to the people of Washington State in November 1991 and euthanasia was narrowly voted against. In Britain, the number agreeing with the statement 'Some people say that the law should allow adults to receive medical help to an immediate peaceful death if they suffer from an incurable illness that is intolerable to them, provided that they have previously requested such help in writing' rose from 69% in 1976 to 75% in 1989. Euthanasia is allowed in The Netherlands. Ethicists have agreed that not prolonging life is acceptable but not actively terminating it. There has been a recent report of the Appleton International Conference on developing guidelines for decisions to forgo life-prolonging medical treatment. Views from 15 countries concluded: 'requests for active termination of life by a medical act which directly and intentionally causes death may be morally justifiable and should be given serious consideration'. However, some are worried that patients may be pressurised to agree to euthanasia while others feel guidelines should be drawn up to avoid illegal 'backdoor' euthanasia. There is also the unanswered question of who would carry out the procedure.

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