PORTUGUESE JOURNAL OF PEDIATRICS

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PERSPECTIVE

Ethics and the "do not attempt resuscitation" order

Ética e a decisão de não tentar reanimar

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Keypoints

What is known

– Ethics and the "do not attempt resuscitation" order has been discussed in medical literature.

What is added

– We review this subject and add our perspective from the field of Pediatrics and Neurology.

Progress in science, technology, and medicine has created a strong belief in the omnipotence of medical care: every problem must have a solution, every disease must have a cure, death is (almost) always avoidable.

Pediatrics is a very special area of medicine because of the enormous emotional investment in children from families and society in general.

Robinson states that the death of a child is always considered a premature death and the acceptance of tragedy is clearly not the state of mind that parents have when a serious, life-threatening disease affects their child[1].

In the practice of pediatrics, the number of patients with advanced and terminal diseases is increasing and physicians and patient representatives have to discuss and agree on difficult topics such as resorting to expensive and potentially harmful pharmacologic interventions, complex surgery with a marginal likelihood of benefit, intubation and mechanical ventilation, and of course what to do in the event of cardiorespiratory arrest.

Physicians have been practicing resuscitation techniques for centuries. The modern era of cardiopulmonary resuscitation (CPR) is mainly founded on the work of cardiologists throughout the 20th century. In 1960, Dr. Kouwenhoven published a landmark paper on the technique of external cardiac massage in the Journal of the American Medical Association[2]. Increasingly sophisticated medical interventions with the aim of restoring vital signs and supporting life are now blurring the dividing line between life and death.

CPR is not always successful and may eventually leave the patient with profound impairments. Also, cardiopulmonary arrest often occurs in patients that already have a severe, chronic, and advanced disease that may seriously and irreversibly compromise their quality of life.

If resuscitation is unlikely to be successful, or if it is successful and the patient's handicap is likely to worsen, can we narrow down the treatment options? On what basis?

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Received: 30-07-2023
Accepted: 19-12-2023
https://pjp.spp.pt

Available online: 10-07-2024
Port J Pediatr. 2024;55(3):181-183
DOI: 10.24875/PJP.M24000444

Some considerations must be made:

– Applying the "low quality of life" standard if CPR successfully restores vital signs is often inappropriate because patients or their families may have a different view on what would be a "good quality of life" or their thoughts on this subject may fall within the framework of a religious belief in the sanctity of life (every human life is intrinsically valuable for most religions worldwide).
– The patient or his/her representatives may be willing to accept a low risk of success in a medical intervention.
– Children have a limited ability to evaluate and decide because of their young age (and sometimes also because of clinical reasons, like advanced neurologic disease). So, healthcare-related decisions fall to a surrogate. Parental autonomy in decision-making about a child's health is not without limits: parents must always consider the best interests of their child. The child has the inherent right to be cared for and to have decisions about their healthcare made on the basis of his/her best interests. The divergence between physicians and parents can result in a conflict between the physician's decisions and physician integrity and parental autonomy. However, a discussion between the medical team and the family on what is in the patient's best interest will, in many instances, not solve the problem and parents may insist on medical interventions that the physician believes to be inadequate and not "evidence-based". Gillam proposes the concept of a "zone of parental discretion" whereby the parents would have the right to make a decision about a specific intervention even if this intervention has a low probability of success (as long as their decision is not malicious and is not harmful to the child). By doing so, the focus on the issue of "the child's best interest" is removed[3]. In the past, cases of disagreement between physicians, institutions, and parents have consistently shown that courts generally recommend that the parents' demand for advanced interventions should be very seriously considered and not easily dismissed as "unrealistic"[4].
– Are moral rules universal and inherent to human nature or do they differ in different times and places? The debate on moral relativism is a major issue today because immigration and cultural changes in indigenous populations have promoted interindividual diversity to an extent that we have never seen before. The beliefs and moral values of physicians and institutions may well differ from those of patients or families from very different ethnic, cultural, socioeconomic, and religious backgrounds.
– In Western societies, unlimited belief in the progress of science and medicine clearly coexists with patients' distrust of physicians' decisions about their healthcare. Moreover, the ability of physicians to prognosticate accurately is notoriously limited.
– Much has been written on the issue of futile intervention[5-8] (with arguments for and against). Some argue that if an intervention is truly futile there is no reason to implement it, so there is always a dividing line between what should be done and what should not. Others say that in extreme cases, a morally-valid agreement may be reached by using the concept of futility: the balance between beneficence, non-maleficence, and the preservation of respect and dignity may favor setting limits for medical intervention. In extreme circumstances, CPR may be successful at restoring vital signs but only temporarily, for a short period of time, and will have no effect on the inexorable course of the underlying disease. In these cases, CPR and other interventions may be considered futile. The concept of futility may therefore be the background for the "do not attempt CPR" decision. It is also very likely that "yes to basic CPR" and "no to advanced CPR" may be a more appropriate option than "no CPR".
– There is also debate surrounding the validity of giving a patient unlimited, advanced, and costly medical treatment that may only bring marginal benefit, perhaps compromising society's healthcare expenses in general. Utilitarian ethics are generally invoked by politicians and economists: a decision is morally valid if it promotes equality in the distribution of resources or, in other words, when it provides "the greatest benefit for the greatest number of people". In opposition to this consequentialist view, deontological ethics states that a morally-valid action is justified in itself and not by its consequences (the right has priority over the Good). In the context of the physician-patient relationship, deontological ethics is of course very compelling.

Our own experience and the literature on this topic[4] suggest that the unilateral decision to not attempt CPR against the will of the parents may create a conflict that entails many legal and ethical problems and must be avoided.

Families of patients with chronic and serious diseases that may experience hyperacute events leading to death are never prepared to discuss with the physician about whether or not to perform CPR in the acute and very stressful situation of cardiorespiratory arrest. Likewise, the physician in charge of the acute event is very unlikely to be the usual caregiver and will have

more limited knowledge of the disease itself and on the specific characteristics of the individual patient. Discussion should therefore anticipate the acute event. It is also advisable to have a written, signed document that can provide proof of the discussion and this should include a clear statement that the review of any decision made should always be considered.

Authors' contribution

José P. Vieira: Conception and design of the study, report, review or other type of work or paper. Drafting the article. Critical review of the article for important intellectual content. Final approval of the version to be published. Agreement to be accountable for the accuracy or integrity of the work.

Funding

None.

Conflicts of interest

None.

Ethical disclosures

Protection of human and animal subjects. The authors declare that no experiments were performed on humans or animals for this study.

Confidentiality of data. The authors declare that no patient data appear in this article. Furthermore, they have acknowledged and followed the recommendations as per the SAGER guidelines depending on the type and nature of the study.

Right to privacy and informed consent. The authors declare that no patient data appear in this article.

Use of artificial intelligence for generating text. The authors declare that they have not used any type of generative artificial intelligence for the writing of this manuscript, nor for the creation of images, graphics, tables, or their corresponding captions.

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