Editor’s Note: As part of our ongoing Medical Ethics series, we offer this POINT/COUNTER-POINT Debate and frame it with the following vignette: At Grand Rounds regarding end-of-life issues, a visiting professor offered that when cardiopulmonary resuscitation (CPR) is unlikely to promote survival with a reasonable quality of life, he shares his assessment with the patient. If the patient does not object, he enters a “no CPR” order in the patient’s medical record.

Point: The Ethics of Unilateral “Do Not Resuscitate” Orders

The Role of “Informed Assent”

Death is prevalent in the ICU. A study suggests that approximately 20% of deaths in America occur in an ICU. Many investigators have shown that the majority of deaths in the ICU involve withholding or withdrawing life-sustaining therapies. There is growing consensus regarding the importance of shared decision making in the ICU, where clinicians and family members work together to make decisions about life-sustaining treatments. However, there remains considerable controversy over the appropriate role of unilateral decisions by physicians to withhold or withdraw life-sustaining treatments. In 1991, the American Thoracic Society defined a life-sustaining intervention as futile “if reasoning and experience indicate that the intervention would be highly unlikely to result in a meaningful survival for that patient” and argued that physicians are not obligated to provide such treatments. The Society for Critical Care Medicine came to similar conclusions. There have been cogent descriptions of the definition and value of this principle in medical decision making and evidence that the principle of futility is currently being used in clinical practice in the United States and around the world. However, there have also been cogent arguments made against the use of the futility principle, and a landmark article proclaimed the “fall of the futility movement” based on these arguments. Currently, there is no general professional consensus about the value and pitfalls of unilateral clinician decision making based on the principle of medical futility. We hope to move this debate forward by reframing the role of unilateral decision making within the context of clinician/family communication and shared decision making about withholding and withdrawing life-sustaining treatments. We propose incorporation of the notion of “informed assent” for some types of these decisions.

The Value and Risk of Informed Assent

In the critical care setting, there are specific circumstances when some standard therapies, such as cardiopulmonary resuscitation, may not provide any benefit to the patient. In these circumstances, are clinicians always obliged to obtain informed consent from patients or family members to withhold or withdraw such therapies? Because the process of obtaining informed consent may cause considerable distress for some patients and family members, we contend that obtaining informed assent—when the patient or family is explicitly invited to defer to clinicians’ judgment in favor of withholding or withdrawing life-sustaining therapy—is an appropriate, ethical alternative.

Recent research suggests that family satisfaction with communication during decisions about end-of-life care in the ICU is higher if clinicians make explicit recommendations and provide the families with support for the decisions made concerning withholding or withdrawing life support. There is, moreover, growing evidence of a significant burden of anxiety, depression, and posttraumatic stress disorder among family members of critically ill patients. Observed risk factors for these psychological symptoms include family involvement in decision making.

Concerns about adverse effects of decision making have been invoked to justify physicians’ withholding of information from patients and families on the grounds of a so-called “therapeutic privilege.” There are considerable risks that unilateral physician decision making to withhold information can cross...
the line between appropriate beneficence and inappropriate medical authoritarianism. This should not mean, however, that clinicians are obliged to ignore the risks of harm to patients and their families from burdens of decision making that they are not prepared to bear, especially when clinicians have reached a clear judgment that the therapy will confer no benefit for the patient. There is a middle ground between wrongful withholding of information from patients and families and harmful impositions of decision-making burdens on them. That middle ground should include the concept of informed assent.

By informed assent, we envision a process in which clinicians provide full information about the risks and benefits of treatments, convey specific recommendations about the medically proposed course, and clearly indicate that the patient and family are entitled to defer to the clinicians’ judgment. As an abstract matter, this is no different from the conventional conception of informed consent: a fully informed patient or family surrogate can always make an affirmative choice to accept clinicians’ recommendations. But as a psychological proposition, informing the patient or family surrogate that they are entitled to accept those recommendations can convey to them the information that the clinicians are prepared to relieve them of unwanted burdens of making life-or-death decisions.

Patients and family members vary in their interest in being involved in medical decision making about end-of-life care. There are some who want to be centrally involved in all decisions, while others want to defer such decisions to the clinicians.20,21 High-quality communication about withholding and withdrawing life support in the ICU must not assume “one size fits all.” An important aspect of this communication is to determine the role an individual patient or family wants to play in such decisions. There are family members who will be greatly relieved that clinicians are willing to take responsibility for decisions, for example, to withhold cardiopulmonary resuscitation when it is not indicated. There are others who will accept a clinician’s determination that cardiopulmonary resuscitation is not indicated but who could not be personally involved in making this decision. However, there are also family members who will feel that being involved in such decisions allows them to provide an important gift to the critically ill patient by ensuring that the patient’s wishes are followed. It is the responsibility of the clinicians to determine where on this spectrum individual patients and families fall and to conduct the communication and decision making accordingly. Moreover, when patients or families disagree with clinicians’ recommendations, we believe that clinicians will need to develop a systematic approach for dealing with such disagreement. The American Medical Association recommends a process be initiated to reconcile differences between clinicians and patients or families, and that life support be continued until reconciliation is achieved.22

Some clinicians may worry about the potential legal ramifications of informed assent. Obtaining informed assent would not require a signed form by patients or their surrogates; indeed, a signature is not necessary even for legally effective informed consent. The signed form is useful as proof in any subsequent legal proceeding that consent was in fact obtained, but there is no special legal significance in the signature as such.23-26 The fact of consent or assent can be adequately documented by other means, such as a contemporaneous medical record entry by the attending physician and/or other clinicians. Optimally, several members of the ICU team would have participated in the family conferences where consent had been obtained; and separate record entries by several of the team members involved would both affirm this best practice and serve as evidence if there were ever a subsequent legal challenge. Even a note in the medical record by a single clinician should, as a legal matter, be sufficient.

Three Categories of Withholding or Withdrawing Life Support

In the ICU, we can identify three categories of decisions to withhold or withdraw life-sustaining therapies that clinicians believe are clearly not indicated; the concept of informed assent is not equally relevant for all three categories. The first category is withholding treatments that patients or family members are not likely to expect for the patients’ specific condition (for example an exploratory laparotomy or activated protein C for a moribund patient with severe septic shock and multiple organ failure); and, accordingly, clinicians need not discuss each treatment withheld if they do not regard it as medically indicated (although clinicians would be obliged to discuss such treatment if a patient or family member takes the initiative to inquire). In this category, decisions about medical futility are commonly made unilaterally and such treatments are frequently withheld without necessarily informing or discussing each treatment with patients and families. This is an entirely appropriate use of medical judgment and consistent with good-quality care, provided the clinicians are careful in the determination that the treatment is not indicated and that the family does not expect the treatment.

The second category is withholding treatments or
procedures that are clearly not indicated but that most patients or families have come to expect. We believe clinicians are obliged to discuss such interventions on their own initiative. Cardiopulmonary resuscitation is currently in this category. It may be that specific patients or families do not in fact expect this intervention. But the expectation is so widespread in our contemporary culture that clinicians should assume that the intervention is expected unless the patient or family indicates otherwise.

The third category is withdrawing a therapy that has already been started but which due to the patient’s clinical course is no longer indicated. Although many medical ethicists conclude that withholding and withdrawing life-sustaining treatments are ethically and legally equivalent, decisions about withdrawing interventions that clinicians have previously viewed as potentially beneficial often have a different and more powerful impact on patients and families than decisions not to initiate therapies in the first place. Accordingly, communication with families about withdrawal decisions should take account of those differences. As in the second category, clinicians should assume that patients or families expect interventions to be continued, once they are begun, unless the patient or family indicates otherwise.

For these second and third categories, we believe that obtaining informed assent to withhold or withdraw interventions is an ethically acceptable alternative to insisting that patients or families always bear the full burden of explicit consent. This alternative should not be offered when clinicians are uncertain about the possibility of success or when the clinicians’ convictions about withdrawing or withdrawing treatment are based on their value judgments about the patient’s resulting quality of life. In these circumstances, there are insufficient grounds for unilateral clinician decisions, and the alternative of deferring to a unilateral clinician decision, which is at the core of the informed assent process, should not be offered to the patient or family. In these circumstances, clinicians may express their opinions and recommendations about the likelihood and desirability of treatment alternatives, but patients and families should be clearly informed that medical expertise has limited relevance in coming to an ultimate decision.

We believe informed assent, in the appropriate context, offers an opportunity to improve the quality of care for patients and families. The ethical propriety of the assenting process depends on clinicians’ careful attention to the particular wishes and needs of specific patients and families. But it is equally true that the process of informed consent demands from clinicians the same communication skills and willingness to spend time with patients and families. Acknowledging informed assent as a suitable alternative in appropriate situations provides an option for protecting patients and families in the decision-making process in a way that the current conception of informed consent does not adequately convey.

J. Randall Curtis, MD, MPH, FCCP
Seattle, WA
Robert A. Burt, JD
New Haven, CT

Dr. Curtis is Professor of Medicine, Departments of Medicine and Medical History and Ethics, University of Washington, and Professor Burt is The Alexander M. Bickel Professor of Law, Yale University Law School.

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Correspondence to: J. Randall Curtis, MD, MPH, FCCP, Division of Pulmonary and Critical Care Medicine, University of Washington, Harborview Medical Center, Box 359762, 325 Ninth Ave, Seattle, WA 98104-2499

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Counterpoint: Is It Ethical To Order “Do Not Resuscitate” Without Patient Consent?

While beneficence, nonmalefiance, and justice are cornerstones of medical bioethics, respect of patient autonomy is arguably the ascendant ethical principle of American medicine. A preponderance of patients believe they should consent to health-care interventions, and > 90% of patients wish to choose or reject CPR during hospitalization. Even though it is most often ineffective, CPR is the only medical intervention that may affect the outcome of cardiopulmonary arrest. Respect of autonomy requires that, when possible, patients have the opportunity to choose even the nature of their deaths (ie, with or without CPR, understanding its risks and benefits). Accordingly, I will argue that, in 2007 America, it is unethical for physicians acting alone to withhold CPR without seeking the consent of the patient or proxy (unilateral do not resuscitate [DNR]). However, it is not categorically unethical to withhold CPR without consent if, in the future, a just process is created, ratified by society, and actuated.

Returning to our visiting professor’s approach, after he shares his medical opinion, possible responses of the patient include silence, vocalized agreement, vocalized disagreement, or request for clarification/discussion. Silence may signify understanding with neither agreement nor disagreement (see below), understanding with agreement, understanding with disagreement or not understanding. Since the patient may not understand the intent of the conversation and silence (ie, no objection) will be interpreted as consent, writing an order for DNR following no objection/silence is unethical. It is DNR by deceit. If the patient understands CPR with its risks, benefits, and alternative, and agrees that it should not be done, the DNR order is appropriate. This is the process of informed consent. If the patient disagrees, the clinician is obliged to ensure that the patient understands CPR and why he feels it is medically inappropriate. Until medical-legal consensus changes, if the patient persistently disagrees, writing a unilateral DNR order is unethical because it disregards the autonomy of the patient.

Is Assent of the Patient Sufficient?

Merriam-Webster notes that “Assent implies an act involving the understanding or judgment and applies to propositions or opinions. Consent involves the will or feelings and indicates compliance with what is requested or desired.” If a clinician says “do you understand that I don’t think CPR is medically appropriate” and the patient responds “yes, I understand,” the patient has technically assented. DNR by assent has several problems. Firstly, the patient may not understand the risks, benefits, and alternatives of CPR; rather, simply that the physician “doesn’t think CPR is medically appropriate.” Secondly, patients have not been told and are not likely aware that assent will result in a DNR order. Assent is applicable with children before they possess capacity. Adult patients are fully capable moral agents whose right to self-determination is undermined if only assent is required. Even if the clinician ensured “informed assent” and explained that lack of objection would result in the DNR order, the validity of the prescription (ie, that CPR is medically futile) relies entirely on the omniscience and values of the physician. Some believe death is the end of their being; and if at stake, patients are entitled to a process that minimizes error of the prescription and is not arbitrary. Unilateral DNR is ethically problematic because of the following: (1) no clinician is omniscient; (2) no clinician is infallible; and (3) the clinician movement. N Engl J Med 2000; 343:293–296
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