Cardiopulmonary Resuscitation at the End of Life Without Patient Consent

An Ethical Challenge to Autonomy and Self-Determination

To the Editor:

We agree that clinicians must disclose all relevant information to patients and families in a manner that they can understand in order to decide voluntarily what can or cannot be done to them. If assent and/or consent process can fulfil this goal, then the patient’s rights of autonomy and self-determination are preserved.1,2

It is a federal requirement that advanced health-care directives including resuscitation preferences are discussed with patients and documented when admitted to Medicare-approved health-care facilities.3 In the absence of such discussions, defaulting to cardiopulmonary resuscitation (CPR) at the end of life for the purpose of organ donation.7 CPR is the default procedure at or near death. Once resuscitation and life support therapy have been initiated, therapy cannot be withdrawn until an evaluation of the individual as a prospective organ donor has been completed by the procurement personnel (section 14 of UAGA 2006).6 Life support therapy to ensure medical suitability of organs for transplantation in a prospective donor cannot be withheld or withdrawn and overrides contrary wishes expressed in advanced directives (section 21 of UAGA 2006).6 The discussion of CPR with patients and families must also address and document their preferences about life support therapy at the end of life for the purpose of organ donation.7

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Informed Nondissent Rather Than Informed Assent

To the Editor:

I read with great interest the debate between Dr. Curtis and Professor Burt on one side, and Dr. Manthous on the other, regarding an “informed assent” approach for do-not-resuscitate (DNR) orders in some cases.1–4 As a pediatric intensivist, I have frequently cared for patients that I believed would not benefit from cardiopulmonary resuscitation (CPR). I have found that many parents agree that CPR would not be appropriate; however, they often express hesitation in bearing the burden of the ultimate decision maker. This is certainly not always the case, but it does happen often. It has been my practice in such situations to do exactly what Dr. Curtis and Professor Burt advocate, and as a bioethicist I have taught this “method” to many critical care physicians, both pediatric and adult. I believe that such a model allows patients or surrogates to be active members in a shared decision-making process without burdening them with the guilt of “letting their loved-one die.” I would, however, advocate a slightly different nomenclature. The term assent connotes an active agreement.5 Indeed, in pediatrics we have taken the term assent to mean the active affirmation of a minor when he or she lacks the legal authority to provide consent.6 As such, I believe that what Dr. Curtis and Professor Burt are advocating is not assent.

When we provide information to patients or surrogates, and state that we will do “X” unless they object, what we are truly seeking is nondissent. What Dr. Curtis and Professor Burt propose, and what many of us do, is use an “informed nondissent” approach. Under such a model, the clinician makes a decision regarding the DNR status of the patient, and informs the family that unless they object the doctor will write a DNR order.

To be clear, such a system requires all the elements of informed consent with the sole exception of the active agreement of the patient or surrogate. Dr. Curtis, Professor Burt, and Dr.