Do not resuscitate: reflections on an ethical dilemma

Summary
This is a reflective account of an ethical dilemma encountered while on placement on a cardiology ward. Reflection is a process which allows practitioners to reveal and expose thoughts, behaviours and feelings that are present at a particular time. All reflective models are based on the principle that purposeful reflection results in a better understanding and awareness, thus enhancing clinical practice (Driscoll and Teh 2001). The Gibbs’ Reflective Cycle has been selected for its simplicity and ease of use to aid personal development. The dilemma was identified and analysed from a professional, ethical and legal perspective. Pseudonyms are used to maintain confidentiality and protect the identities of all parties involved.

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The patient and the dilemma
The first stage of Gibbs’ Reflective Cycle (Gibbs 1988) (Figure 1) asks the reflecotor to describe the events. Rebecca, an 83-year-old woman, was transferred from another ward in the hospital to a cardiology ward after developing cardiac arrhythmia. She was initially admitted to hospital for significant weight loss which, on investigation, was found to be a result of advanced bowel cancer with liver, bone and brain metastases. Within 24 hours of being transferred to the cardiology ward, her condition deteriorated rapidly and medical staff conferred with her family about what they should do in the event of cardiac arrest. Involving relatives in discussions about end-of-life issues allows for appropriate decisions to be made and helps to ensure that all parties involved understand the situation (McDermott 2002).

The meeting with Rebecca’s family resulted in the decision to initiate a do not resuscitate (DNR) order. The purpose of a DNR order is to deliberately withhold life-saving measures when a patient’s cardiac or respiratory function ceases suddenly (Costello 2002). The local trust resuscitation policy emphasises that prolonging a patient’s life should provide a positive health benefit to the patient and not prolong life at all cost, with no regard to its quality. However,
Cardiopulmonary resuscitation (CPR) can deny patients a dignified and peaceful death by prolonging the process of dying (McDermott 2002).

During handover it was discovered that the doctor had not documented the DNR order and the nursing staff were immediately concerned because the patient’s condition was deteriorating rapidly. According to Jevon (1999) discrepancies sometimes occur and nurses should be prudent and check the patient’s notes to confirm his or her DNR status, as was the case in this situation. A member of the nursing staff bleeped the on-call registrar to explain the situation and expressed her concerns. The doctor on-call had been involved in the DNR proceedings and said that he would come to the ward as soon as possible. The patient went into cardiac arrest shortly after. A cardiac arrest call was put out and the coronary care nurse (CCN) and the author (JJ) arrived at Rebecca’s bedside in seconds, and were confronted with the dilemma of whether or not to resuscitate her.

The CCN was the nurse-in-charge of the shift and had been involved in the discussions concerning the patient. However, as she was the first staff member on the scene who was trained in advanced life support, she had to decide whether or not to start CPR, which could be perceived as two equally unsatisfactory alternatives (Thompson et al 2006).

**Influences on decision making**

The key ethical principles surrounding end-of-life decisions and resuscitation are (Baskett et al 2006):

- Autonomy.
- Beneficence.
- Non-maleficence.
- Justice.

McDermott (2002) identifies similar ethical principles but replaces justice with veracity. These principles can be used to guide decision making in resuscitation. On reflection, adhering to one principle can mean that other principles are compromised. In other words, there is no right or wrong answer, and all of these principles can be applied to end-of-life issues.

A decision by the CCN not to start CPR would be likely to have been based on numerous factors.

The principle of non-maleficence generates the obligation not to harm others (Edwards 1996), and would oppose performing CPR when its use is inappropriate or its outcomes would cause harm (McDermott 2002). It could be argued that not performing CPR would result in the ultimate harm – death, although this was inevitable in Rebecca’s case because of advanced malignancy.

**FIGURE 1**

**The reflective cycle**

- **Description**
  - What happened?
- **Feelings**
  - What were you feeling and thinking?
- **Analysis**
  - What sense can you make out of the situation?
- **Evaluation**
  - What was good and bad about the experience?
- **Conclusion**
  - What else could you have done?
- **Action plan**
  - What would you do if it arose again?

(Adapted from Gibbs 1988)
Evidence for cardiopulmonary resuscitation

Guidelines, published by the Resuscitation Council (UK) (RCUK) (2001) in conjunction with the British Medical Association and the RCN, state that no benefit is gained from CPR if only a brief extension of life can be achieved and the patient’s co-morbidity is such that imminent death cannot be prevented. Many people have an unrealistic view of the benefits of CPR. Their knowledge is often obtained through television dramas, which are rarely realistic (Dean 2001).

The rates of hospitalised cardiac arrest patients who survive to discharge following resuscitation are low, ranging from 6.5% to 15% (Biegler 2006). Cardozo (2005) states that CPR is successful in 20% of patients, but concedes that not all of these survive to the point of hospital discharge. Factors believed to be associated with poor outcomes of CPR include the presence of underlying metastatic disease (Schultz 1997).

On analysis, had Rebecca been able to express her wishes before her condition deteriorated, staff could have taken these into consideration. Under English law, adults are always presumed to be capable of making healthcare decisions unless the opposite has been demonstrated (Department of Health (DH) 2001a). This is echoed by the Nursing and Midwifery Council (NMC) (2004) in section 3.4 of the NMC Code of Professional Conduct which says: ‘You should presume that every patient and client is legally competent unless otherwise assessed by a suitably qualified practitioner. A patient or client who is legally competent can understand and retain treatment information and can use it to make an informed choice.’ However, medical staff were unable to consult with her about the DNR order because she no longer had the capacity to consent because of her metastatic disease.

Capacity and paternalism

In adults, where doubt exists, the individual’s capacity should be assessed by a medical practitioner, drawing on the assistance of specialist practitioners if necessary (DH 2001b). The criteria for capacity, outlined by the DH, involves the patient’s ability to understand and retain information about the decision, understand the consequences of having or not having the intervention, and using and evaluating this information in the decision-making process (DH 2001b). In situations where a patient lacks the capacity to make his or her own decisions or communicate his or her wishes, staff do not have any other option but to act in, what is in their opinion, the patient’s best interest (Dimond 2006). In some circumstances this might be construed as medical paternalism, a term that means ‘doctor knows best’. The healthcare profession has traditionally been paternalistic (Beauchamp and Childress 2001) where professionals believe that they are best placed to make treatment decisions for patients. However, the healthcare professions have begun to shift away from this paternalistic approach with government directives promoting patient empowerment (DH 2001c). Therefore, situations in which healthcare practitioners remove decision making from the patient require clear justification (Hutchinson 2005).

Ethical analysis

Paternalism often conflicts with autonomy, which is defined as self-governance or self-determination. According to Thompson et al (2006), the term ‘autonomy’ came into prominence through the 18th century philosopher Immanuel Kant who argued that to be held a fully rational, responsible moral agent one must be an autonomous person. The right to self-determination suggests that patients should be treated as autonomous individuals able to control their own activities and destinies and have the right to elect voluntarily whether to consent to treatments and procedures (Polit and Beck 2006).

Registered practitioners are obligated to respect patient autonomy under section 3.2 of the NMC Code of Professional Conduct (NMC 2004), which in part states: ‘You must respect patients’ and clients’ autonomy – their right to decide whether or not to undergo any health care intervention – even where a refusal may result in harm or death to themselves…’ However, in this case, Rebecca was unable to be autonomous because of impaired capacity.

The obligation of non-maleficence could also influence the CCN’s decision not to resuscitate because of the potential physical damage caused by chest compressions. The trauma of CPR in the presence of bone metastases puts the patient at high risk of sustaining rib fractures. Nurses have to be aware of the possibility of litigation as relatives and patients may complain and legal action is becoming more common (Oxtoby 2005). Negligence is the absence of due care (Beauchamp and Childress 2001) and, under this definition, initiating CPR potentially imposes a risk of harm. However, negligence might also be applicable if CPR is not started – something which will ultimately result in the patient’s death.

Professional responsibility

Alternatively, the principles and issues that support initiating resuscitation are equally valid. The CCN would have to consider the absence of
documented DNR order. Once the DNR decision has been made, the most senior member of the medical team should document it in the patient’s health records (Jevon and Raby 2002). This was not done in this case. If nothing has been documented in the patient’s notes then resuscitation should be carried out (Pennels 2001). The haphazard recording of DNR orders is widespread and practitioners should remember that failure to initiate resuscitation, without a DNR order, would be considered negligent (Jevon 1999). A patient has a fundamental right to CPR and medical and nursing staff have a duty to perform it (Costello 2002). Article 2 of the Human Rights Act 1998 imposes a duty to provide adequate and appropriate medical provision to preserve life. DNR orders infringe on the right to life and practitioners must be able to provide clear justifications (McDermott 2002).

**NMC Code of Professional Conduct** As well as a legal duty, the CCN was bound by a professional duty under section 1.3 of the NMC Code of Professional Conduct to resuscitate the patient. It states that registered practitioners are personally accountable for their practice and are, therefore, answerable for their actions and omissions, despite the advice or directions from another professional (NMC 2004). The NMC has the power to remove or reprimand any registered practitioner who is found guilty of professional misconduct (NMC 2004). Failing to perform CPR could have jeopardised the CCN’s career and it is unrealistic to believe that she would not have considered this.

There are other sections in the NMC Code of Professional Conduct that support starting CPR. It states that practitioners are expected to uphold and protect the patient’s interests and wellbeing (NMC 2004). This is the ethical principle of beneficence, which means to always do good (Hendrick 2000), and to act for the benefit of the patient (UK Clinical Ethics Network 2006). In this case under the principle of beneficence, the CCN should act to benefit the patient and resuscitate her. However, facilitating a peaceful and dignified death could also be viewed as a beneficent act.

The ethical principle of veracity is also pertinent to both the NMC guidelines and the issue of resuscitation. Veracity is the principle of truthfulness, honesty and sincerity (Hek et al 2002). Section 7 stipulates that practitioners must be trustworthy and uphold the reputation of the profession (NMC 2004). In this case the CCN could have decided not to resuscitate the patient and then asked the on-call registrar to issue a DNR order afterwards. This would be a highly questionable practice and could lead to professional misconduct proceedings being initiated against her, because it violates the principle of veracity. Nonetheless, it could be argued that it would be a non-maleficent act towards the patient.

**Ethical theories**

The main ethical theories that inform these alternative choices are deontology and utilitarianism. The deontological approach supports an action as right, if it accords with a moral rule, irrespective of the outcome or the purpose (Noble-Adams 1999). This approach would justify the nurse performing CPR because he or she would be following legal, professional and NHS trust rules to which he or she is bound. Utilitarianism is an ethical doctrine in which an action is morally right if it produces good consequences (Noble-Adams 1999). Therefore, choosing not to resuscitate the patient could be defined as morally right because the consequence allows her to die peacefully and with dignity. However, a decision to resuscitate may allow Rebecca and her family more time to prepare for her death.

**Feelings and reflective evaluation**

The CCN chose to start CPR but she stated that she felt uncomfortable in light of the patient’s condition and the author (JJ) echoed her feelings. The patient was emaciated and the author began chest compressions with extreme trepidation. Chest compressions are traumatic in a relatively well nourished patient, so the effect on a patient with malignant cachexia can be devastating. Rundell and Rundell (1992) suggest that: ‘To nurse a patient to a dignified death, uncomplicated or uncompromised by CPR is often a much harder challenge than simply jumping on their corpse when they falter’. However, this attitude is changing and many nurses encounter situations where the DNR status of a patient causes them concern (Payne et al 2000). They frequently express ethical concerns about maintaining the life of a person who has either a poor quality of life or little time left (Costello 2002).

As we continued, the rest of the ‘crash team’ arrived and took charge of the situation. The anaesthetist and doctor were briefed and empathised with the CCN’s dilemma. They agreed that, in light of the DNR order not being documented in the patient’s notes, it had been wise to act cautiously and attempt to resuscitate the patient. After approximately five cycles, the doctor in charge decided to cease and all parties involved unanimously agreed. If it becomes evident that the underlying cause renders the situation futile, then
resuscitation should be abandoned if the patient remains in asystole (Baskett et al 2006).

The dilemma versus the problem. On further analysis, this incident was a true dilemma, because it contained the five defining attributes of a dilemma (Sletteboe 1997) which were discussed earlier. The CCN was involved in the dilemma because she was ultimately responsible for making the decision to resuscitate the patient. The alternatives were equally unattractive, leaving her to make the choice between inappropriately resuscitating the patient—thus preventing a dignified and peaceful death—or not commencing CPR and risking legal action and charges of professional misconduct. She was also aware of the available alternatives and the need to make a choice. Although it could be argued whether or not Sletteboe’s (1997) fifth defining attribute—the uncertainty of action—applies to this situation, the CCN’s extensive practical experience as a senior staff nurse on the cardiology ward suggests that she would have been aware of the consequences of either resuscitating Rebecca or not.

Conclusion

The author did not agree with the CCN’s decision to resuscitate Rebecca but she did understand why the decision was made. Healthcare professionals face dilemmas on a daily basis and these vary between vital life and death decisions that have to be made in a matter of seconds, to dilemmas where time constraints are not a major issue. In the latter, time can be taken to evaluate the alternatives carefully, but in the former decisions are expected to be made instantaneously, as was the case in this example. Nurses are expected to make these decisions based on their knowledge of ethical principles and best judgement, which is informed by a professional code. However, nurses are human and can make mistakes for which they are then professionally accountable. On reflection, this situation has raised the author’s awareness of the ethical principles that inform the decision-making process. The insight I have gained from this experience will inform my future practice.

References


Hutchinson C (2005) Addressing issues related to adult patients who lack the capacity to give consent. Nursing Standard. 19, 23, 47-53.


