Is It Always Wrong to Perform Futile CPR?
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Although there is currently much debate about the types of care to which patients are entitled, one thing on which everyone can agree is that non-beneficial care should be eliminated. Although such care can be hard to define, in some circumstances experienced clinicians can be virtually certain that attempts at resuscitation will fail. In these cases, many argue that hospitals should adopt policies that allow physicians to refuse when families demand futile cardiopulmonary resuscitation (CPR).

Several years ago, I cared for a 2-year-old boy who had been born with a large frontal encephalocele. He survived surgical excision but was left neurologically devastated. The clinical team consistently counseled his parents that he would never have any meaningful neurologic development. We recommended redirecting his care toward comfort and palliation. The parents rejected all these suggestions. I came to know the family fairly well through the boy's multiple admissions to the intensive care unit (ICU) where I am a physician. Despite extensive and continual efforts by everyone involved to support the family and reach an agreement to limit aggressive treatment, the parents continued to insist that everything be done.

I vividly recall the evening when, a few minutes after a “code blue” was called over the hospital intercom, I watched this little boy being rolled in through the doors of the ICU. He appeared chalky and lifeless; I remember thinking that he might already be dead. Still, mindful of his father’s unyielding refusal to consider a “do not resuscitate” order, I instructed the staff to attempt resuscitation. We ventilated the boy through his tracheostomy and made multiple unsuccessful attempts to place central venous and intraosseous lines. After perhaps 15 minutes, I asked the team to stop. I pronounced the boy dead. None of us felt good about what had just happened. One of the nurses later told me that it had been so upsetting she had had to fight back the urge to vomit.

I went to talk to the parents. They had arrived at the hospital a short time after the code blue was called and were holding their little boy. I fully expected to be on the receiving end of an angry tirade full of accusations about our failure to keep their son alive. Instead, the mood was remarkably quiet and somber, as they began...
the universal grieving of parents for a lost child. But what surprised me the most was when the father gently opened his son’s shirt, revealing all the puncture wounds and bruises from our failed attempts to place a subclavian catheter. He looked up at me and said, “I want to thank you. I can see from this that you really tried; you didn’t just give up and let him die.”

There are many reasons why my decision to attempt resuscitation that evening might have been wrong. Our ethical obligations are to our patients, not to their families. Certainly we should never do anything harmful to a patient for the benefit of others. But that seems to be exactly what we did here — engaged in futile and brutal resuscitative efforts to placate a family that didn’t accept reality as we saw it. Were our actions a form of child abuse?

This family’s continued insistence on all life-sustaining treatments did not reflect our failure to properly counsel them about an appropriate plan of care for their child. We are as good at that as we are at resuscitation. So did we have an obligation to override their demands and withhold futile resuscitative efforts? Might not our acquiescence to their misguided demands have sent a wrong message to the community, implying that we are willing to compromise our medical standards and provide useless treatment when confronted by intransigent families?

Given the already heavy workloads of physicians and nurses, is it reasonable to pull some of the hospital’s most senior and experienced clinicians away from their duties to engage in a “sham” procedure, potentially compromising the care of other patients? Did I fail in my leadership role within the ICU by contributing to the burnout that is becoming a plague in ICU medicine?

I have wondered about all these questions over the years. I know that I do not have convincing answers to most of them. I understand the arguments against what I did. Yet I still believe that, all things considered, we did the right thing for this patient and family on that evening.

Most families want their loved ones to be peaceful and comfortable when death is near. Some patients and families, however, do not share this vision of a “good death.” For some, it is very important to believe that they fought until the very end. This may be particularly true for families who, like this one, may have to recount the story of their loved one’s death to friends and relatives in parts of the world where modern ICU care is nonexistent, and for whom the idea of “giving up” despite the availability of such seemingly limitless technology would be deemed wrong and inconceivable.

Although the interests of the patient are always primary, at the end of life there are times when the interests of the patient begin to wane, while those of the family intensify. Family members may live for years with the psychological aftereffects and regrets of end-of-life decisions. In these situations, the interests of the surviving family members may take priority. At the time we began our resuscitation efforts, I believed that this child was beyond suffering, whereas the psychological needs of his parents were both clinically and ethically significant.

Are there any lessons to be learned from stories like these? Clinicians and hospitals are divided about the ethics of performing futile CPR for the benefit of family members. There is inconsistency even among the teaching hospitals of Harvard Medical School. Some have policies that permit clinicians to refuse to provide nonbeneficial CPR, whereas others explicitly reject this approach and insist on agreement between the clinicians and the patient or family before CPR is withheld.

On balance, either approach may be too limiting. Nonbeneficial CPR should never be performed when it would cause substantial suffering or when the demands of the family are clearly at odds with the interests of the patient. The diversion of hospital resources to nonbeneficial care should not occur if there is a credible threat to the health of other patients. Fur-
thermore, as in all resuscitation attempts, clinicians should use their clinical judgment and discretion in deciding on the length and intensity of resuscitation efforts. Decision making in medicine is likely to become even more complex as clinical practice becomes increasingly directed by guidelines, outcomes research, and comparative-effectiveness analyses. But actions surrounding the moment of death are highly symbolic and often of great significance to the surviving family. By sometimes agreeing to provide futile CPR, we send a message to our communities not that clinicians can be bullied into performing procedures that good medical judgment would oppose, but that our hospitals are invested in treating patients and families with respect and concern for their individual needs. The message to our medical and nursing colleagues is not that they can be forced to perform brutal and unnecessary procedures on their patients, but rather that — in a small number of cases — providing nonbeneficial CPR can be an act of sincere caring and compassion. Futile CPR has a limited but legitimate place in the practice of medicine.

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Failing to Thrive
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My mother and I were on vacation in New York when we got a call from my aunt and uncle, both psychiatrists, in Portland, Oregon. My 90-year-old, demented paternal grandmother seemed to be having a stroke. They wanted to know whether they should take her to the emergency room.

“She’s stuporous,” my mother, a cardiologist, relayed to me, an internal medicine resident at the time. “Acting funny.”

“Stuporous?” I asked. “Are we talking near-coma stuporous?” Maybe there was a less foreboding, psychiatric type of “stuporous.”

A Do Not Resuscitate—Do Not Intubate order had been signed, and there was some murmuring about a family decision to allow no further emergency room visits. I glared at my mother: no one had told me. But no written advance directive could be found. My father and eldest uncle, also physicians, were out of the country; my third uncle, an attorney, was in D.C., and my grandfather, a retired physician, was theoretically too demented to make the decision (though he, despite his frequent reflection that “pneumonia is an old man’s best friend,” wanted nothing short of heroics for his beloved wife).

We quickly flew back to Portland, where I found Deedee, as we call my grandmother, sitting in her bed, cheeks flushed, thinning hair pushed straight back. She said, “Hi, dear” (thus avoiding having to identify me by name) and apologized for not wearing makeup. Then she turned back to her disconnected phone and tried to call her mother, who had died 10 years earlier at the age of 100. In her prime, Deedee was brilliant. She never forgot a name, phone number, address, birthday, or recipe, and she could beat any Jeopardy champion while ironing and talking on the phone. She now suffered from an intractable delusion that she was on a road trip and couldn’t reach her mother to check in.

Her skin was clammy, and her breathing rattly. One of her caretakers mentioned in passing that her oxygen saturation that morning had been 79%.

I immediately called my own mother. “Should I bring her into the emergency room?” I asked.

“We have to be circumspect,” she said.

I told her Deedee’s oxygen saturation. “Oof,” she said.

Then she asked, “What does Dad think?”

I called my father, en route from China, who said, “What does your mom think?”

I said, “She told me to call you.”

“Well, what do you think?” he asked. “Do you think she is dying?” This was a milestone: he had never before asked my medical opinion. Until he used that word, despite the overwhelming evidence before me, I hadn’t been willing to consider that this, in