CPR for patients in a persistent vegetative state?

Dr. Charles Weijer's article "Cardiopulmonary resuscitation for patients in a persistent vegetative state: Futile or acceptable? (*CMAJ* 1998;158[4]:491-3) is based on a serious misinterpretation of the Joint Statement on Resuscitative Interventions (Update 1995),[1] which is CMA policy.

Weijer claims the statement indicates that physicians can withhold cardiopulmonary resuscitation (CPR) against family wishes when the patient is in a persistent vegetative state (PVS). He cites 3 passages from the joint statement:

- "There is no obligation to offer a person futile or nonbeneficial treatment."
- "People who almost certainly will not benefit from CPR are not candidates for CPR, and it should not be presented as a treatment option."
- "People who have rejected CPR and those who almost certainly will not benefit from it should not be given this treatment if an arrest occurs."

However, these passages do not address the question posed by Weijer or substantiate his claim. The issue of decision-making authority with regard to CPR, which includes the determination of what counts as "futile" or "nonbeneficial," is dealt with in the statement's general principles. As for proxy decision-making in the hypothetical case described by Weijer, the statement advises that "treatment decisions must be based on the person's best interests, taking into account: (a) the person's known values and preferences, (b) information received from those who are significant in the person's life and who could help in determining his or her best interests, (c) aspects of the person's culture and religion that would influence a treatment decision, and (d) the person's diagnosis and prognosis. In some jurisdictions legislation specifies who should be recognized as designated decision-makers (proxies) for incompetent people; this legislation should be followed." The joint statement does not provide a conflict-resolution mechanism in cases of dispute between family members and physicians or other care providers.

Because of Weijer's misinterpretation of these passages, his conclusions "that this aspect of the joint statement is neither ethically nor legally defensible and hence that hospitals ought not to rely upon this aspect in their own policy statements" must be firmly rejected. Moreover, his accusation that the statement "does not allow physicians to respect choices for life-preserving therapy that are rooted in religious belief" is contradicted by passages that call for facility policies to "ensure sensitivity to cultural and religious differences" and for "open communication, discussion and sensitivity to cultural and religious differences among caregivers, potential recipients of care, their family members and significant others." Regarding futile or nonbeneficial treatment, the statement encourages policy-makers to "determine how these concepts should be interpreted in the policy on resuscitation, in light of the facility's mission, the values of the community it serves, and ethical and legal developments." The joint statement's overall message is the polar opposite of Weijer's notion that it "amounts to saying to families, 'Your values don't count.' "

As he is entitled to do in an editorial, Weijer presents a single viewpoint on medical futility. Since there is no consensus on this issue, the joint statement takes a cautious approach, avoiding the extremes of affirming the right of patients or their proxies to choose any treatment and requiring physicians to refuse to provide treatments that they consider futile.[2] This topic is the subject of ongoing study by the statement's sponsors.[3] The outcome may well be a document that supplements the statement, but Weijer's demand that the 1995 statement and hospital policies based upon it be amended to deal with his concerns is entirely unjustified.

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References

1. Joint statement on resuscitative interventions (update 1995). *CMAJ* 1995;153(11):1652A-C.
2. Williams JR. How is the new statement on resuscitative interventions different from the original? *CMAJ* 1994;151(8):1182-3.
3. Williams JR. Consensus finally achieved on resuscitative interventions. *CMAJ* 1995;153(11):1641-2.

Dr. Weijer argues that an ethical analysis favours a family's right to request CPR for a 65-year-old patient in a PVS with no hope of recovery. He thinks this request should be honoured in Canadian hospitals and, implicitly, that the costs should be borne publicly.

Even if there was enough public money to cover these costs, I am not persuaded that the proposed intervention would be more appropriate than many others, some of which might also prolong life. Moreover, in today's world there will be no increase in spending, and the proposed expenditures on patients in a PVS would lead to reduced spending on other patients. I am not convinced that the redeployment of resources to support the cost of CPR in these cases would be favoured by most Canadians over any present health expenditure. Until society decides to the contrary, there are no compelling ethical, moral or legal arguments favouring the preferential allocation of resources to support the cost of CPR in these cases.