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Essay

Cardiopulmonary resuscitation beyond the technique☆

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ABSTRACT

This reflective article presents the current state of cardiopulmonary resuscitation (CPR) and reviews it from a bioethical standpoint. It starts with the ineffectiveness of CPR and the reasons why today it is a universally applied procedure, sometimes without taking into consideration the wishes or condition of the patient. Possible courses of action for the continuous improvement of cardiopulmonary resuscitation are proposed, especially from the humanistic point of view. Greater involvement of patients and their families in medical decisions, particularly in the planning of medical management rather than in the acute phase of the disease—as is the case for CPR—is encouraged.

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Reanimación cardiopulmonar más allá de la técnica

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RESUMEN

En este articulo de reflexión se presenta el estado actual de la reanimación cardiopulmonar (RCP) y su revisión bioética. Se parte de la poca efectividad de RCP y las razones por las cuales hoy en día es un procedimiento de aplicación universal, en ocasiones sin tener en cuenta el estado o deseos del paciente. Se presentan posibles caminos de acción para el mejoramiento continuo de la reanimación cardiopulmonar especialmente desde el punto de vista humanístico. Se incita a una mayor participación de los pacientes y sus familiares en las decisiones medicas, especialmente en la planeación del manejo medico mas que en el momento agudo de la enfermedad, como es el caso de la RCP.

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Introduction

Anesthesia is considered to be a leading specialty in cardiopulmonary resuscitation (CPR), the supervision of clinical practice guidelines, and specialized courses in the field. As such, a rational analysis of CPR instructions should be initiated, at the level of scientific societies. This is due to the fact that even though CPR is administered with good intentions, and it is an extraordinary medical intervention that is capable of preventing premature death, it can also disastrously prolong the death process, thereby increasing the suffering and stress experienced by the patient and their family, and spending—futilely—economic resources that are important for society.[1,2]

Despite advances in technique and new medications, the effectiveness of CPR continues to be low. Only a small percentage of the people that suffer a cardiac arrest manage to survive and be discharged. Paradoxically, for the general public and for the majority of physicians, if there is no "do not resuscitate" order, there is no reason to not initiate chest compressions, administer electric shocks, and intubate all patients in cardiac arrest.[3] We can be sure that, today, CPR is one of the few medical interventions that everyone hopes to perform.

Asking when not to perform CPR generates concern and controversy, as it is a rarely discussed theme. As Brindley[2] asserts in an editorial of the British Journal of Anaesthesia, this takes place because the majority of the literature focus more on the technique than on who is being resuscitated.

Historical development of CPR

Modern CPR was described by (among others) Peter Saffar and his collaborators in the 1960s. The intervention was meant for treating witnessed cardiac arrests in operating rooms. Although none of the pioneers of this technique ever proposed that it should be a universally performed procedure,[2] little by little it was disseminated to the point that the error was committed of assuming that any person—no matter the place or the patient—could perform CPR. The use of the CPR technique expanded rapidly, not only among physicians but also among the general population. The popularity of this procedure grew and became so strong that today it is seen as "obligatory" to perform cardiopulmonary resuscitation maneuvers on all patients in cardiopulmonary arrest. This is so common that, in the majority of cases, dying in a hospital means undergoing CPR.[4]

The success of CPR

Although the success rate for the immediate restoration of circulation after an in-hospital cardiac arrest is close to 60%, only between 6.5% and 24% of patients with cardiac arrest leave the hospital alive.[5] This does not take into account the patient's neurological status or their quality of life. For the rest of the patients—that is, for the 76%–93.5% for whom CPR was not successful—this maneuver can be considered an extension of the patient's dying process. With this prolongation, the dying period could be increased by hours or days in an intensive care unit. The wide range of success (between 6.5% and 24%) depends on whether or not the cardiac arrest was witnessed, among many other factors. In hospitals' general services, the success rate is much lower than in operating rooms or in the ICUs (where the majority of cardiac arrests are witnessed and the resuscitation maneuvers are initiated rapidly). There are other factors that are considered to be independent predictors of death in the first 24 h after a cardiac arrest. Examples include being male, and the non-shockable cardiac arrest rhythms: pulseless electric activity and asystole.[6]

Why has CPR become so widespread?

Based on moral arguments that claim that patients have the right to the opportunity to survive, the procedures of CPR, have been justified for years, generally, without the consent of the patient or their family.[7] These procedures including external chest compressions, tracheal intubation, venous cannulations, electric shocks and the administration of medications, Little by littel, and due to multiple factors, CPR went from being an intervention directed toward patients with reversible cardiac arrest causes, to being an indiscriminately administered intervention, converting almost completely into a social right, one that is occasionally even demanded by patients and family members.[2]

The reasons for which physicians perform CPR maneuvers on all patients that suffer a cardiac arrest—and for which the general population demands this behavior—are probably a mix of factors that gradually became engrained in clinical practice and in society. Among these factors are some that depend directly on physicians, the patients, the influence of television and other media, and so forth.

Physician dependent factors

Among the factors that depend on the physician are the fear of legal persecution or medical-legal problems; and the fear of therapeutic failure—the difficult-to-judge limits between giving up and continuing. Perhaps a "Do Not Resuscitate" order (DNR) is still misinterpreted as "abandoning the patient". We may suppose, in the same way, that is cases like this, progress is usually interpreted as "doing more" and never as "doing less".

Medical teaching is based on "doing"—doing interventions, doing procedures. Very rarely do we teach to "not do" and to talk with the patient. The preference toward "doing" before "not doing" may bias the physician toward aggressive treatment strategies ("doing" strategies) starting in their training. Although effective, the traditional focus of medical teaching centers more around medical duties than on the patient. This focus is not always respectful of the patients' wishes and goals.

Another factor that depends on the physician, and that is not always explicit, is the desire to avoid difficult conversations with patients and their families. Holding a conversation with them about death and the possibility of a DNR can be morally taxing. Many physicians adopt a posture that could be considered to be easier and less compromising morally: not speaking, not commenting, and, if cardiac arrest occurs,

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