Thinking twice about the rush to give CPR to COVID-19 patients

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Hospitals across the U.S. still face the possibility of their intensive care units being maxed out due to the COVID-19 pandemic, leading some front-line physicians to wonder whether it might ever be appropriate to unilaterally withhold cardiopulmonary resuscitation (CPR) to the sickest patients. In some circumstances, according to medical ethics experts, the answer is yes.

The AMA has created an ethics resource page, "DNR orders in a public health crisis," that offers expert advice on when and why this extraordinary measure may be ethically justifiable. Citing numerous opinions from the AMA Code of Medical Ethics, the page provides a comprehensive guide to the ethical questions in play.

More broadly, the AMA and the Centers for Disease Control and Prevention are closely monitoring the COVID-19 pandemic. Learn more at the AMA COVID-19 resource center. Also check out pandemic resources available from the AMA Code of Medical Ethics, JAMA Network™ and AMA Journal of Ethics®, and consult the AMA’s physician guide to COVID-19.

Why it’s an issue

Ordinarily, the patient or surrogate is vested with authority to accept or request orders not to resuscitate, the resource page notes, citing opinion 5.4, “Orders Not to Attempt Resuscitation (DNAR).” In addition, the opinion specifies that physicians should provide resuscitation when the patient’s wishes are not and cannot immediately be known.

“But there have been conversations during the COVID-19 pandemic about making it a mandate, so it’s not a decision between patient and physician,” said Elliott Crigger, PhD, director of ethics policy at the AMA. “There’s a lot of concern around that, but there’s also good reason for withholding CPR, beyond the probable lack of benefit to the patient.”
Given the intense activity that ensues during a resuscitation, there is heightened risk to health care workers, Crigger noted.

CPR involves multiple staff, and extubating the patient creates an opportunity for transmission at a very high level," he said. "If the patient had an appreciable chance to recover to discharge, that would make it a much harder call. But evidence indicates that for COVID-19 patients on ventilators, CPR is very unlikely to be successful, while there is very clear risk to health care workers."

Check out the ethics resource page on obligations to protect health care professionals.

Weighing benefit and risk

That low chance of recovery alone is enough to justify withholding CPR to intubated patients, the resource page says. Opinion 5.5, “Medically Ineffective Interventions,” directs physicians to recommend and provide only those interventions that are medically appropriate.

It also says that physicians must not offer or provide care that "cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care."

So if no clinical benefit is expected from CPR, the page says, “opinion 5.5 thus allows physicians to withhold it without explicit consent from the patient or surrogate even under usual conditions."

But opinion 8.3, "Physicians’ Responsibilities in Disaster Response and Preparedness," goes further. While it establishes physicians’ responsibility to provide care even at risk to themselves, it also directs them to balance the risks of caring for individual patients with the need to be available to provide care in the future.

“In a public health crisis, the goal is to maximize benefit (and minimize harm) for the greatest number of patients,” the page says. “Carrying out CPR for a patient who is being treated for a severe, highly contagious disease may pose an unacceptably high level of risk for health care professionals involved in the resuscitation effort, especially when there is little likelihood the patient will survive.”

The AMA ethics resource pages—which now address more than a dozen issues at the heart of the COVID-19 pandemic, including crisis standards of care, fair access to limited critical care resources and prioritizing the rest of health care in a public health crisis—have been developed based on inquiries from physicians and policymakers.