ELSEVIER

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Editorial

☐ THE ETHICS OF EMERGENCY RESUSCITATION

For the emergency physician, issues surrounding end-of-life decision-making can be quite complex. Volume 34, Number 4 of *The Journal of Emergency Medicine* included an article that reviews substantial points about the attitudes of South Korean emergency physicians towards resuscitation (1). It is relevant for physicians to analyze the controversies surrounding resuscitation and withholding or withdrawing life support in the hospital environment, and to attempt to reach some consensus regarding these difficult decisions. It is significant, therefore, that the authors indicate that only a minority of the physicians they surveyed worked in institutions that had ethics committees, with an even smaller number having formal guidelines for resuscitation in place. As such, these physicians practice without the structural support and guidance that such bodies provide. These practice circumstances likely will require individual physicians to approach life-and-death decisions without the benefit of valuable peer input.

In the United States, there are widespread efforts to use Do Not Resuscitate (DNR) orders in suitable cases, in an effort to prevent inappropriate initiation of cardiopulmonary resuscitation (CPR). According to the authors, identification of DNR patients occurs in only a quarter of settings in South Korea, and a significant majority of physicians polled had received no educational training in discussing mortality with family members. Emergency physicians in South Korea, therefore, may face considerable obstacles concerning communicating with families regarding patients in whom resuscitation efforts have been terminated, as well as in identifying those patients who have previously declared against resuscitation efforts.

Perhaps to explain their findings, the authors assert that most responders in their study were aware of the illegality of euthanasia under Korean law. However, euthanasia is not the province of emergency medicine. A much more common scenario involves the necessity to withdraw life-sustaining treatment from patients with a futile prognosis. With regard to this, less than half the physicians in this study had conducted active withdrawal of such treatment.

Many responders report that they had recently practiced invasive procedures on immediately deceased patients without the consent of family members. Performing such procedures has a long history as a teaching practice and is likely widespread. The practice is based on the presumption that no harm can be produced, whereas considerable benefit could accrue to trainees. One study looking at the prevalence of performing procedures on the recently deceased at United States emergency medicine training programs found that in approximately half of the surveyed settings, this practice was utilized for teaching purposes. However, this was done without obtaining consent from family members in three-quarters of these programs (2).

It has recently been suggested that permission for this activity should be obtained routinely. The recommendation of the American Medical Association's Council on Ethical and Judicial Affairs, for example, is that family members be approached to provide consent for such procedures (3). There is, however, no standardization among hospitals with respect to policies addressing this issue. One study comparing North American with European institutions found that a majority of family members at both responded affirmatively when they were approached to approve post-mortem procedures (4). However, physicians are likely concerned that requesting such permission risks angering the bereaved. It has been suggested that a preauthorization program similar to organ donor cards might be an acceptable way to provide consent for post-mortem procedures (4). This concept may reflect the fact that patients have been shown more likely to authorize procedures upon themselves than would family members who were asked to consent on their behalf (5).

A culturally significant characteristic of traditional Korean society that is described is that the presence at one's parent's deathbed constitutes an important duty. This applies particularly to the eldest son. The authors emphasize that some family members asked CPR to be continued until the patient's eldest son arrived at the hospital. In some cases, relatives took a firm stand against terminating CPR before this individual was present, even after health care providers had made maximum resuscitative efforts This tradition should be familiar to all physicians caring for Korean patients.

Another point of discussion is that of family members witnessing resuscitation efforts. A number of benefits to such familial presence have been proposed. These include maintaining family–patient connectedness and facilitating family grieving through demonstration that everything medically possible is being done. Family presence would also remove uncertainty regarding what was happening to the patient during the resuscitation. Medical personnel have often shown little enthusiasm for this practice, however. When surveyed, a substantial number of emergency providers reported negative experiences with family presence, and they additionally failed to observe any positive value (6). Medical staff members often assume that witnessing a resuscitation would be traumatic to relatives, but this is not necessarily the case. In one study, family members who witnessed resuscitations reported fewer symptoms of grief 3 months after the experience (7).

A recent survey performed in Singapore assaying health care workers confirms that Emergency Department (ED) staff is likely to oppose families witnessing resuscitations, considering such presence to constitute a hindrance to providing proper care. The authors provide a specifically Asian interpretation for their findings. Citing conservative Asian values towards resuscitation and death as the reason, they express the observation that, whereas family presence is gaining currency in Western countries, the practice is practically nonexistent in Asia (8).

Witnessing of resuscitation by a family member has, indeed, become more common, and in light of expanding autonomy for patients and family in the current health care climate, it seems likely to increase further. The parallel has been posed with the experience of expectant fathers, who were once denied access to the delivery room, but whose presence there is commonplace today (7). Moreover, it has been suggested that witnessing resuscitation actually produces a beneficial effect on the relationship between emergency staff and relatives (7).

When considering resuscitation in the ED, regardless of the country where this is practiced, emergency physicians face multiple ethical challenges. The decision to resuscitate or not has to occur in the context of many different factors. Additional issues of family presence at resuscitation and performance of peri-mortem procedures likewise demand our attention. The issues are complex and require careful understanding.

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