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Reply to comments on 'The ethics of resuscitation'

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The authors of the paper 'The Ethics of resuscitation' published in 'Anaesthesiology Intensive Therapy, 3/2011, are grateful for the interest in the issues addressed to and opinions on involvement of hospital ethics committees in decision making regarding resuscitation and the extent of treatment of ITU patients.

No doubt, in the hospital setting, the only person qualified to make decisions of institution of resuscitation or not is a physician. The Code of Medical Ethics (art. 32, point 2) states that 'the decision to discontinue resuscitation rests with physician and should be based on the assessment of likely therapeutic success' [1].

According to the European Resuscitation Council, the decisions in question are complex and affected by individual factors, local and international culture, legal issues, tradition, religion as well as social and economic aspects; all these factors should be considered before decision-making. In some cases, the decisions can be made in advance yet sometimes the immediate actions have to be undertaken based on insufficient data. Therefore, end-of-life decisions and their ethical implications should be included in education programmes, discussions, training courses of health care workers to improve their individual, ethical competence [2].

Recommendations of the bioethical committee should not be binding for physicians, thus they cannot limit their due decision-making powers or free them of responsibilities for the final decision undertaken. Yet the nature of committee opinions is disputable. Should they be confined to indicate and emphasise some relevant ethical aspects or additionally recommend the solution of a given conflict [3]? The advisory role of hospital committees is comprehensively discussed in the article published in 'Anaesthesiology Intensive Therapy, 1/2010. This advisory and not decisive function is also included in the name of one of such Polish committees, i.e. the 'Advisory Committee on Clinical Ethics' [4].

Hospital ethics committees in making decisions to withhold resuscitation or to determine the extent of treatment of ITU patients should not focus on opinions about validity of undertaking or discontinuation of resuscitation in each individual case but fulfil educational, regulatory and consultative functions; although, the last one should concern only the most difficult, conflicting and controversial situations. As rightly pointed out by the authors of comments, individual consideration of all cases is impossible, enough to mention the organization-related issues. Due to the advisory role of committees and obligation of physicians to make final decisions, their verdict in a given case should be based on opinions of the team of experts. It appears that the goal of committees should not be to make the binding decision but to deepen reflections and to present various points of view in a particular situation. Such a role of committees solves the dilemma whether the final decision should be unanimous, or based on the majority vote or *votum separatum* .

In practice, the opinions concerning institution or termination of a given therapy, including resuscitation, may vary within one therapeutic team. For instance, great differences were demonstrated in opinions of physicians and nurses on limitations of resuscitation and treatment of extremely premature newborns [5, 6]. The involvement of committee experts in discussions of such situations could help in better understanding of the situations and opinions of various parties, in explaining doubts and agreeing on the common approach.

The authors of the comments are right that institution of therapy, including resuscitation, when the therapeutic success is potentially slender, is not doing any good for patients, leads to prolonged suffering and agony and fulfils the criteria of futile therapy and malpractice. The resuscitation guidelines published in 2010 state that in the cases where resuscitation is unlikely to be beneficial for prolongation of acceptable-quality life, its institution is futile [2]. On the other hand, what is the acceptable quality of life in general terms and for the patient that the decision concerns? What is the good of the patient? While seeking the answers to these questions and interpretations of the fundamental notions, such as the acceptable quality of life or the patient's good, which constitute the basis of opinions presented in 'The ethics of resuscitation', should not the opinions of experts of hospital ethics committees be useful and helpful?

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