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Letter to the Editor

A critique of the recent 2018 ERC CPR guidelines

This letter offers a normative critique of the recent 2018 European Resuscitation Council Update: Antiarrhythmic Drugs for Cardiac Arrest.[1]

The recent guidelines maintain their earlier recommendation to prioritize Amiodarone over Lidocaine in cases of refractory shockable-rhythm cardiopulmonary resuscitation. The guidelines maintain this recommendation because both Amiodarone and Lidocaine were recently proven to have equal effects on rates of discharge from hospital post-CPR even though Lidocaine was proven to be more effective in gaining ROSC.[2] This was in fact a normative decision, based more on moral deliberation rather than on empirical evidence.

The arguments made against this recommendation include the following: First, patients and families may value the extra time gained by the use of Lidocaine over Amiodarone to prepare for the patient's demise. Second, the use of Lidocaine over Amiodarone, and thus more time before a formal declaration of death, might mean more organs available for donation, thus benefiting society and other individuals.

The arguments made in favor of this recommendation include the following: First, more patients surviving to ROSC but not to discharge will translate into increased financial burden on healthcare systems. Second, and most importantly, 21 out of 24 participants of a survey conducted for the purpose of informing the guidelines claimed that Amiodarone would remain their first-choice drug regardless of the ERC recommendation. These respondents also claimed that Amiodarone is readily available and widely used, its effects well known, and that training healthcare providers to use Lidocaine may be cumbersome.

The authors of the recommendation document should first be praised for their transparency and what was clearly a thorough discussion prior to the drafting of the document. However, since these are normative arguments, one wonders why bioethicists, social scientists and economists were not part of the deliberation. Second, since these normative arguments rely on quantifiable information, e.g. number of organs potentially made available for donation or extent of burden on society, one wonders why no data gained from modeling or actual empirical studies were used or at least called for.

Generally, expertise in the science of resuscitation does not equal expertise in the ethics of resuscitation. In ethical deliberations, empirical data may and should inform the ethics, but they may not become the ethics. Specifically in this case, if the use of Lidocaine would mean more organs available for donation, it may outweigh the concern for the consequent costs as well as the concern regarding the training of healthcare providers.

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