

COMMUNICATING ABOUT CARDIOPULMONARY RESUSCITATION AND DO NOT ATTEMPT RESUSCITATION DECISIONS

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ABSTRACT

As the boundaries of medicine are pushed, and life prolonged further, it is increasingly evident that healthcare and modern medicine no longer simply equate to a prolongation of life at all costs; actually, decisions not to attempt cardiopulmonary resuscitation (CPR) may be in a patient's best interests. This article discusses how we discuss these complex decisions with those affected by them: our patients.

INTRODUCTION

Healthcare is not simply about prolonging one's life at all costs. When respiratory or cardiac arrest is part of the expected process of dying, then, not attempting cardiopulmonary resuscitation (CPR) is in the patients' best interests, allowing them to die with dignity and peacefully. Yet reports of poorly made decisions about CPR have appeared in the international press and receive much attention from the general public.¹ Prompted by these reports, guidelines were released by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing in 2001, and these are updated regularly. These give guidance on various ethical and legal principles governing CPR.² One of these key principles is the paramount importance of communication and provision of information to the patient and family. However these conversations may be fraught with difficulty for healthcare providers, patients and families, making some doctors reluctant to address the issue. Yet the importance of decisions relating to CPR mean that, despite their complexity and sensitivity, open and frank communication between the healthcare team and patient is essential.

COMMUNICATING ABOUT CPR WITH PATIENTS

The first step lies in ascertaining whether the patient wishes to discuss CPR or not. Patients approaching the end of their life may have directly or indirectly indicated that they are not interested in having this discussion; therefore burdening them with discussions on interventions from which they will obviously not benefit is needless. The amount of involvement a patient has in these discussions should be tailored to fit their indicated desires.

Dunn et al.³ outline the key aspects of a discussion on CPR:

- Discussing the current medical condition, including information on prognosis and disease progression;
- Eliciting goals and values for care;
- Discussing CPR in a manner that adheres to criteria for informed consent.

The value of performing CPR is greatly dependent on the physical condition and underlying disease process, but while the doctor may be aware of the medical status of a patient, for a variety of reasons, including their own wishes, the patient may be less well-informed. However, someone who is unaware of the prognosis cannot adequately discuss CPR, as that individual is unable to balance the probable outcomes with or without CPR. A conversation about CPR and do not attempt resuscitation decisions (DNARs) should be a discussion of patient goals, quality of life, and what treatments are most likely to achieve these. Goals change with time and illness so discussions about goals of treatment should be done throughout the duration of the patient's life-limiting disease and not simply at the very beginning, or during the final dying process. Early on in the





course of a life-limiting disease the aim of treatment may be to prolong life enough to see the birth of a granddaughter or nephew, while further on during the course of this disease the aim may be to spend the final hours at home surrounded by family.

Patients often fear the loss of control that might occur in the final phases of their life. Advanced care planning gives patients a sense of control and ensures that their wishes are followed even if they become incompetent.⁴ Patients should be given honest answers regarding the practical aspects of CPR and treatment post-CPR, but this should be given at a level the patient understands. It may be easy to get sidetracked into discussing unimportant medical technicalities, which may easily lead to misunderstandings; yet information should never be withheld simply because this is too complex or difficult for the healthcare team to explain adequately.^{4,5} It should be clear to the patient that offering an intervention, such as CPR, does not necessarily mean that the doctor thinks that it will work and that it is the right thing to do. It should be clear that refusing such intervention is an equally valid choice. Cases popularized in the media, or past experience with family members may have resulted in specific concerns about both under-treatment, and poor outcomes after cardiac arrest such as a persistent vegetative state. It is important to try and understand the basis of these concerns and explain them appropriately. For example, patients may not wish to be put on ventilators because “they may never wake up”; this should prompt a discussion on non-initiation of treatment or withdrawal of treatment, as this patient may wish to have a trial of invasive ventilation but would not wish to be ventilated indefinitely.⁶

Maltese legislation does not provide any reference to the concepts of CPR, DNARs and living wills. As such, determination of CPR status remains a clinical decision based on the professional capacity of the clinician in charge, taking into consideration the socio-cultural background of the patient.

WHERE ARE WE FAILING PATIENTS?

Yuen et al.⁷ suggested that problematic DNARs often failed in one or more of four areas:

- Discussions held too infrequently, with patient preferences being neglected;

- DNAR discussions delayed until it is too late for the patient to participate;
- Inadequate information to facilitate informed decisions;
- Inappropriate extrapolation of DNAR to other treatments.

Three of these areas relate directly to communication with patients, further underlining its importance. These are not problems of technology, lack of equipment or even finances, but a medico-cultural framework that has resulted in inadequate communication by healthcare providers.

CONCLUSION

Despite evidence showing that patient priorities for end-of-life care include consistent, reliable medical advice and avoiding inappropriate prolongation of the process of dying, the medical establishment often persists with a cure-driven culture and for various reasons is often reluctant to engage the patient in an informed discussion on prognosis, values and goals of care, and CPR. A discussion between all healthcare providers on how we have failed to communicate with patients and families at the end of life is required before we can start to improve our communication with our patients.³ ❌

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