

# Six Steps to Help Seniors Make the CPR/DNR Decision

■ There's a lot of misinformation and misunderstandings when it comes to cardiopulmonary resuscitation (CPR) or a do not resuscitate (DNR) order. Here's an insider's view and six steps you can follow to help seniors have meaningful conversations to make this critical decision and feel confident it is right. **BY VIKI KIND**

A common and extremely important decision seniors face when writing their advance health-care directives or experiencing a medical crisis is whether to choose cardiopulmonary resuscitation (CPR) or to request a do not resuscitate order (DNR). There is a lot of misinformation and misunderstandings when it comes to the CPR decision. As a Certified Senior Advisor (CSA)<sup>®</sup>, you are in a position to provide relevant and accurate information to help seniors and their families make a decision that reflects the senior's values and health goals.

## How CPR has changed

CPR used to be very simple to understand. *Cardio* stands for heart; *pulmonary* stands for lungs; and *resuscitation* means to revive from

death. In the past, when a patient died, someone would push on the person's chest to try to restart the heart while giving mouth-to-mouth resuscitation to help the person breathe. But over time, CPR has become more complex as health-care professionals discover different and advanced ways to try to bring a person back to life. What seemed like an easy question,

"Does the person want CPR?" has turned into a decidedly complicated decision.

## Do you want to be a DNR?

There are three ways to say "do not resuscitate"—DNR, DNAR, and AND; the differences are very important. The second choice, "do not *attempt* resuscitation" (DNAR), more appropriately explains that just because you attempt CPR doesn't mean it will work.

The third and newest term, "allow natural death" (AND), is a more gentle way of saying "do not resuscitate." Instead of telling you what won't be done for the senior, the doctor is offering the senior a peaceful, natural death without resuscitation efforts. Along with introducing the concept of allowing a natural death, this language creates an opportunity to discuss what the senior might envision at the end of life, as well as the benefits of hospice and palliative care.

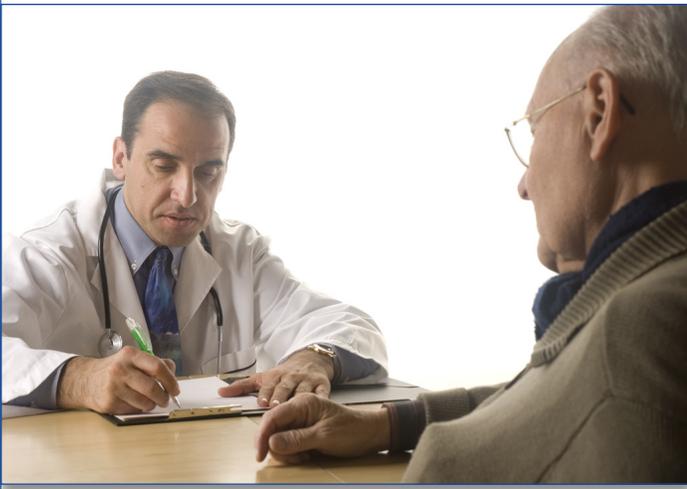
## Steps to having the CPR/DNR conversation

As a clinical bioethicist, my approach to the CPR/DNR conversation is threefold:

- Educate the person about CPR.
- Help the person put the medical decision into the context of his or her life.
- Have the person make the decision.

For more information on the CPR versus no-CPR discussion, click [here](#) to see a webinar by Viki Kind, "Making the End-of-Life Decisions Meaningful," at Member Resources >> Webinars & Videos in the CSA Member Portal.

advanced ways to try to bring a person back to life. What seemed like an easy question,



If the senior or the senior's decision maker would like your assistance, the following steps will help you guide and support the person in making a choice that represents the senior's values and health goals.

### Step 1: Inform

#### Ask the senior, "What do you know about cardiopulmonary resuscitation (CPR)?"

Most seniors will say, "They push on your chest, blow in your mouth, and/or shock you with paddles." You need to explain that CPR also includes *medications* to help restart your heart and *intubation*, which means they put a tube down your throat. Also, you will be put on a *breathing machine* (sometimes called a ventilator or a respirator). I have been shocked to see how many seniors are outraged when I tell them what really happens during CPR, because they never would have chosen to be put on a ventilator. They are also angry that they didn't have all the facts.

Another option that may be offered is the misleading choice of being a "chemical code only," which means medicine will be given but no chest compressions. As nurses and doctors will tell you, if the doctor gives the medicine but doesn't do the chest compressions to move the blood around, the medicine will not circulate in the body. Without circulation, the medicine cannot do its job. That said, if family members can't accept that the senior is going to die, this choice is occasionally offered, even though it very probably won't work. Some seniors, families, and physicians also find

comfort in this choice because "something is being done." But as a bioethicist, I don't think people should be offered options that have no benefit. If a person wants CPR, then he or she should choose everything CPR offers to have a chance at being brought back to life.

### Step 2: Explain

#### Help seniors understand the chance of CPR working for them.

If you ask health-care professionals, "How many of you would like to die by CPR?" no one ever raises a hand. What they know is that the chance of CPR working is minimal—sometimes even 0 percent. On television shows such as *ER*, CPR brings the patient back to life about 75 percent of the time (Diem, Lantos, & Tulskey, 1996), but in real life it only works, at best, 17 percent of the time on healthy patients (Peberdy et al., 2003). In many situations, the chance of success is zero.

In the article "CPR Survival Rates for Older People Unchanged," by Serena Gordon (2009), William Ehlenbach, M.D., the lead author of a study on CPR in the elderly, explains that "CPR has the highest likelihood of success when the heart is the reason, as in an ongoing heart attack or a heart rhythm disturbance. If you're doing well otherwise, CPR will often be successful. But, if you're in the ICU [intensive care unit] with a serious infection and multiple organ failure, it's unlikely that CPR will save you."

### Step 3: Discuss

#### "You may come back to life in a worse condition than you were before, both mentally and physically."

Most people don't understand what can happen if CPR brings someone back to life. When the health-care team is pushing on the person's chest, there is a chance of broken ribs or a collapsed lung. The longer the patient isn't able to breathe, the greater the chance is for brain damage. There may also be damage to the

windpipe if the person is placed on a ventilator.

Another way that television shows mislead you is by letting you think a person will be healthy enough to go home about 67 percent of the time (Diem, Lantos, & Tulsky, 1996). In reality, if CPR is able to bring the patient back to life, the chance of this person going home with good brain function is about 7 percent (Kaldjian et al., 2009). Some patients may survive CPR but are never able to leave the hospital. Others may remain hooked up to ventilators for the rest of their lives. The success rate will depend on the health of the patient, the patient's age, how quickly the CPR was begun, and other medical factors.

#### Step 4: Reflect

**“The type of death you may be choosing with CPR may not be the kind of death you want.”**

With CPR, the senior might not have the opportunity for a peaceful and profound death experience. When you picture the last minutes of a person's life, do you see strangers straddling the patient on a bed, pushing on the patient's chest, while the family waits outside in the waiting room? Or do you see a time with family and friends gathered around the bedside, with words of love being expressed, music being played, or prayers being said?

The CPR decision is about more than medicine. It frames the dying experience for the patient and their loved ones. I would encourage people to balance the chance of CPR working and bringing the person back in a good condition with the desire for a dignified death. This is why many health-care professionals wouldn't want to die by CPR; there is nothing peaceful or dignified about this type of death.

#### Step 5: Clarify

**“I want to make sure you understand there may be a time in your life when you would want CPR and a time when CPR would no longer be an option you would choose.”**

### » 5 CPR Decision-Making Tips for Seniors

1. Make sure you understand what really happens during CPR.
2. CPR doesn't work like you see on television.
3. CPR will not change the underlying cause of your condition, and it might make you worse.
4. Think about the kind of death you are choosing.
5. The decision about CPR is only one part of a good end-of-life plan.

This is where to stop and re-emphasize the difference between choosing CPR when you are healthy and choosing CPR at the end of your life. The senior's medical instructions should clarify in what health condition the senior would choose a DNR. The senior might say, “While I am still healthy and able to interact with the people I care about, I would want to receive CPR. When I near the end of my life, or when I can no longer enjoy spending time with my loved ones, I would not want to receive CPR.” This decision is more than a “medical choice”; it is really a quality-of-life choice. Thus, the senior will need to define what makes his or her life worth living.

#### Step 6: Process

**Moving the medical decision into the context of the senior's life.**

At this point in the conversation, the goal is to help the senior process what he or she has just learned. Let the senior lead the conversation and explore what CPR represents to him or her. Leave some silence for the senior to consider the significance of these issues. If the senior is hesitant, you can try asking one of these questions: “For many people, CPR just prolongs the dying process. What do you think

about this?” or “Is there value in fighting until your last breath, even if this might increase your suffering?”

But don't rush the senior because you are uncomfortable in the silence. He or she may need some time to think about what you have shared. You might also encourage the senior to take his or her time with the decision by saying, “You don't need to make a decision about this today.”

## What else may affect the decision?

### **Decision maker's emotions**

As a bioethicist, I get called in to resolve conflicts when a loved one is demanding CPR for the patient and the doctor is frustrated because he or she knows CPR won't work since the person is terminal. When a family member says to me, “I won't sign the DNR,” I ask the person, “Why don't you want to sign it?” Then I listen. The demand for CPR may be desperation, grief, guilt, familial obligations, religious beliefs, a fear of death, misunderstanding what CPR can do, or a reaction to a past negative experience with the health-care system.

The other day, a family was refusing to sign the DNR and the health-care team thought that they were refusing because they were very religious. It turns out that the family was not making the decision based on their religious values. They were refusing to sign the DNR because a family member had once come back to life when everyone had said there was no hope. Given their experience, they believed not only that miracles can happen, but that they do happen. Once the health-care team understood the family's perspective, it made sense to them why the family was so insistent on “doing everything.”

### **Professional's beliefs**

As professionals, we may get caught up in thinking we always know what is best for the clients we are serving. We approach these

situations with our own perspective about what would be the “right decision.” But these types of choices are not about us and our agendas—they are about the senior.

It is important to educate the senior about CPR but then you have to let the individual make his or her own decision. These end-of-life conversations are a process, not a one-time event. Don't push the person to sign the DNR. Pushing the senior will erode the trust he or she has in you and will create a confrontational relationship.

## When the person wants CPR and the doctor's choice

If the person chooses CPR, I would encourage the senior to find out if the hospital has a family presence policy that allows loved ones to witness any attempts at resuscitation. Being able to be in the room has been shown to help the family feel comforted by knowing that all efforts were made to help their loved one. The family will also have the opportunity to say good-bye during the CPR attempt, instead of being told after the fact that the senior has died. Of course, the hospital has the right to refuse to have the family in the room if the family is disruptive.



There are times when a patient can want CPR but the doctor can refuse. This is when CPR no longer has a chance of working and is therefore no longer a valid medical option. A patient cannot make the doctor give an ineffective or non-beneficial treatment, and sometimes CPR falls into that category because it simply won't work.

Another issue is when certain doctors won't agree to a DNR because of moral opposition. While doctors are allowed to live by their morals and to refuse to participate in acts that go against their values, they are still obligated to let patients know about valid medical options and then let the patient or the decision maker decide. If the doctor is unwilling to do this, then he or she should help the patient find a physician who will discuss and honor the DNR decision.

Lastly, make sure that the DNR request in an advance directive is transferred into the hospital chart. If the DNR is not on the chart, it doesn't exist. Encourage the senior or the decision maker to review the advance health-care directive with the health-care team in the emergency room and again when moved to an inpatient room.

Our role as CSAs in the CPR/DNR conversation is to educate, to understand the senior's perspective, and to support the person who has this difficult choice to make. Encourage the seniors and the families you work with to ask for a meaningful conversation with their health-care providers. The ultimate goal is to ensure that the senior's health goals are listened to and respected. ■

For more information on advance directives, see "A CSA's Guide to Advance Directives: Helping Seniors Plan" in the *CSA Journal* 49, and "Introductory Guide to Advance Directives" in the Free Resources section of the SCSA website.



**Viki Kind** is a clinical bioethicist, professional speaker, hospice volunteer, and author of the award-winning book *The Caregiver's Path to Compassionate Decision Making: Making Choices for Those Who Can't*. She can be reached at [viki@kindethics.com](mailto:viki@kindethics.com) or at [www.TheCaregiversPath.com](http://www.TheCaregiversPath.com).

## References & Related Reading

- Diem, S. J., J. D. Lantos, and J. A. Tulsky. 1996. "Cardiopulmonary Resuscitation on Television: Miracles and Misinformation." *New England Journal of Medicine* 334: 1578-82.
- Ehlenbach, W. J., A. E. Barnato, J. R. Curtis, W. Kreuter, T. D. Koepsell, R. A. Deyo, and R. D. Stapleton. 2009. "Epidemiologic Study of In-Hospital Cardiopulmonary Resuscitation in the Elderly." *New England Journal of Medicine* 361: 22-31.
- Gordon, S. 2009, July 1. "CPR Survival Rates for Older People Unchanged." *HealthDay: News for Healthier Living*.
- Kaldjian, L. C., Z. D. Ereksion, T. H. Haberle, A. E. Curtis, L. A. Shinkunas, K. T. Cannon, and V. L. Forman-Hoffman. 2009. "Code Status Discussions and Goals of Care among Hospitalised Adults." *Journal of Medical Ethics* 35(6): 338-42.
- Peberdy, M. A., W. Kaye, J. P. Ornato, G. L. Larkin, V. Nadkarni, M. E. Mancini, R. A. Berg, G. Nichol, and T. Lane-Truitt. 2003. "Cardiopulmonary Resuscitation of Adults in the Hospital: A Report of 14,720 Cardiac Arrests from the National Registry of Cardiopulmonary Resuscitation." *Resuscitation* 58(3): 297-308.