Avoiding the Pitfalls in CPR/DNR Decision Making

About Viki Kind, MA:

Viki Kind is a clinical bioethicist, medical educator and hospice volunteer. Her book, "The Caregiver's Path to Compassionate Decision Making: Making Choices for Those Who Can't," guides families and healthcare professionals through the difficult process of making decisions for those who have lost capacity. Patients, families and healthcare professionals have come to rely on Viki's practical approach to dealing with challenging healthcare dilemmas. She has also been a caregiver for four members of her family for many years.

Educational Objectives:

Examine the obstacles to good DNR decision making.
Discuss what is CPR and the perceived vs. actual chance for success.
Demonstrate best practices for communicating about CPR.
Consider how the signing of the DNR is just one component of end-of-life care.

Background:

Older adults and their loved ones are being asked to make difficult end-of-life choices about CPR (cardiopulmonary resuscitation) and its refusal, DNR (do not resuscitate). These decisions are fraught with emotional angst and misinformation. In the past, we only used CPR on patients who were having a heart attack and who might benefit from receiving CPR. Now we use it for everyone, including those in a terminal state, whether it will work or not.

One of the complicating factors is that CPR used to be very simple to understand. Now, the general public doesn't realize that when the doctor says CPR, she is including medications, intubation and ventilator support. A common misunderstanding occurs when people are given the misleading choice of a "chemical code only." 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 can not do its job.

Another factor is that the decision about CPR has inappropriately become an indicator of a person's complete end-of-life wishes—but the decision about CPR should be only one part of the treatment plan. A patient may want chemotherapy, surgery, radiation therapy or other kinds of aggressive treatments and still may want to be a DNR. Or the person may not want other medical treatments but still want to receive CPR. These are all separate decisions and any combination is possible.

One positive change is that the language of DNR has been modified to "do not *attempt* resuscitation" *(DNAR)* or "allow natural death" (AND). Both of these help to clarify the confusion. Do not *attempt* resuscitation truthfully explains that just because CPR is attempted, doesn't mean it will work. If you ask healthcare professionals, "How many of you would like to die by CPR?" No one ever, ever raises a hand. What they know, but don't always share with their patients, is that the chance of CPR working is minimal, sometimes even 0 percent. On television shows like *ER*, CPR brings the patient back to life about 75 percent of the time (Diem, Lantos and Tulsky 1996), when in real life it only works, at best, 17 percent of the time on healthy patients (Peberdy, et al. 2003). In many real-life situations, the chance of success is zero.

William J. Ehlenbach, MD, lead author of a study of CPR in the elderly, published in the *New England Journal of Medicine* in 2009, explains, "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" (quote from Gordon 2009; study published by Ehlenbach et al. 2009).

The newest term, *allow natural death* or AND, is a more gentle way of saying *do not resuscitate*. Instead of stating what won't be done for the patient, the doctor is offering to allow the patient a peaceful, natural death and will not attempt resuscitation. Because the CPR/DNR decision is about more than medicine, it frames the dying experience for the patient and the loved ones. For those who are making the CPR/DNR decision, it is important to balance the chances

of CPR working and bringing the person back in a good condition with the desire for a good, peaceful and dignified death. This is why healthcare professionals wouldn't want to die by CPR; there is nothing peaceful or dignified about this type of death.

Case study 1:
Mr. Jackson is a 67 year old gentleman who has end-stage Alzheimer's, is unable to eat and recently had a feeding tube placed. The patient does not have an advance directive and never told his kids what he would want done and unfortunately, his doctor didn't ask about his CPR wishes when he was in the early stages of the disease. The physician is now asking, "Would he want CPR?" His adult children have been through a lot over the past years and are overwhelmed by the question. The thoughts running their minds are, "Is it time? Are we giving up? I don't want to make this choice but I can't stand watching him suffer any longer. If I make this decision, does that mean I have lost my faith?"

How can the healthcare team help guide the adult children through this decision making process? What are the underlying issues that will make the decision more difficult to make? What statistical information might make the decision easier? What grief support can the healthcare team provide to ease the process?

Discussion – Mr. Jackson:

How can we as aging professionals help those we serve as they struggle with these difficult decisions? One of my roles as a bioethicist is to assist families, like Mr. Jackson's, who are making the difficult decisions. I am not there to tell the family or healthcare team what to do, but to help those involved to think through the issues so they can make a more informed decision. It is important during these conversations that we keep the *patient's* wishes and needs at the forefront.

When working with Mr. Jackson's son and daughter, I would make sure they are educated about CPR. Hopefully, Mr. Jackson's doctors will not have eroded the trust and created a confrontational relationship by pushing for the DNR. I would need to be patient as these end-of-life conversations are a process, not a one-time event.

I would make sure Mr. Jackson's children understand the possible outcomes of CPR. He may survive CPR but never be able to leave the hospital or he may be hooked up to ventilators for the rest of his life. Research has found if CPR is able to bring a patient back to life, the chance of the person going home with good brain function is about 7 percent (Kaldjian, et al. 2009). And in Mr. Jackson's compromised condition, his chances are even lower. The typical success rate of CPR will depend on the health of the patient, the patient's age, how quickly the CPR was begun and other medical factors.

Next, I would make sure that the family understood what can happen during CPR. Mr. Jackson may be brought back to life but in a worse condition than before, both mentally and physically. There is a chance of broken ribs, a collapsed lung, damage to the windpipe, and the longer he isn't able to breathe, the greater the chance for brain damage.

Once the family understands the likely chance of CPR working and what kind of outcomes might be expected, I would then point out that by discussing that by choosing CPR, Mr. Jackson may not have the opportunity for a peaceful and meaningful death experience. I would ask his children, "When your father pictured the last minutes of his life, did he see strangers straddling him on a bed, pushing on his chest, with his family waiting outside his door? Or would your father want his family and friends gathered around his bedside, with words of love being expressed, music being played or prayers being said?" By asking these important questions, I am helping to contextualize the medical choices by explaining what it will be like for their father to experience CPR versus a more peaceful death.

Another common issue I may have to address is to relieve the guilt and angst of those making these difficult decisions. One gift I may be able to give Mr. Jackson's children is to help them understand that it not really their decision. It is the patient's decision. I would explain that as the decision makers, they are supposed to consider all that they know about their dad, what he has told them in the past, what his values are, and what would be important to him. Using this

information, they should do their best to make the decision they think their father would make.

I would gently ask, “What would your dad be telling us if he were able to understand what has happened? What would your dad say about wanting CPR?” And then I would be quiet and let them sit with the question. In most situations, the family will know the answer but it will be painful for them to verbalize the choice. I would then acknowledge how loving and courageous they are to honor their father’s wishes. No matter what decisions are made, it will be important that this family receive emotional and spiritual support as they struggle with these issues.

Case Study 2:

Mrs. Garcia is an 83 year old woman who has multiple sclerosis. Her advance directive states that she does *not* want CPR. Her multiple sclerosis has developed to the stage where she has lost the capacity to speak for herself. Her husband is her decision maker and caregiver and he knows her wishes. Last week, Mrs. Garcia suffered a heart attack and is now in the ICU. This morning she coded and was brought back to life by CPR. Her husband has just been called to come to the hospital and was told that his wife survived CPR but her condition is deteriorating. What went wrong? Why wasn’t her DNR honored? What is Mrs. Garcia’s expected outcome after receiving CPR?

Discussion - Mrs. Garcia

What went wrong?

Unfortunately, this scenario happens more often than it should. When Mr. Garcia got the call about his wife, he was shocked and angered. How could this happen?

There are a few possibilities. Some doctors won’t agree to a DNR because of moral opposition and therefore won’t write or respect a DNR. 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 decision-maker decide. If the doctor is unwilling to do this, then the doctor should help the patient to find another doctor who is willing to talk about the DNR option. If the patient, family or someone from the healthcare team is worried about the patient's rights being violated, he or she should call for a bioethics consult from the hospital's bioethics committee.

Another possibility is that the DNR request from her Advance Directive was not transferred onto her hospital chart. If the DNR is not on the chart, it doesn't exist. Whether you are the patient, the loved one or someone working with the family, make sure you go over the patient's Advance Directive and other healthcare wishes with the doctor and make sure they are documented.

A final possibility is that medical miscommunication occurred. Perhaps the advance directive wasn't sent up from the emergency room, the team couldn't find the DNR, no one took the time to look for it, the on-call physician wasn't familiar with the patient or numerous other mishaps. As much as the public would like medicine to be perfect, healthcare is significantly flawed and human.

What should happen next?

The first step will be to make sure the DNR order is written immediately. I would hope that apologies would come next. Administration, risk management and other hospital staff will be involved in resolving this situation. This event will be evaluated to determine what caused this medical error and to take steps to make sure it doesn't happen again. (But it will happen again, but usually not to the same patient.)

Ultimately, the doctor will need to sit down and to talk about where to go from here. Since the CPR was performed, what condition is the patient in? What options are available which would be respectful of Mrs. Garcia's wishes? Is it time for a hospice referral? The doctor who performed the CPR may not be the best person to handle the situation at this point because of the broken trust. It may be necessary to bring in a different consultant to help bring peace to this situation. It will also be important to address Mr. Garcia's anger and frustration with the hospital and the healthcare team. He will probably

be devastated that his wife's wishes were not honored and that she is still suffering. Appropriate social services should be brought in to help him with his grief.

Upon evaluation of the event, it appears that it wasn't that Mrs. Garcia's wishes weren't respected, but her wishes were not known (because no one read her advance directive) and the CPR/DNR conversation never occurred. This is also a common problem in healthcare. Many physicians are uncomfortable talking about end-of-life issues. I would hope that healthcare professionals don't just talk about the medical choice of CPR but would also talk about what kind of life one would want after CPR and what kind of death is desired. The following questions are just as important as, "Do you want CPR?"

Where would the person want to die?
Whom would the person want to be with as he or she dies?
What would bring peace and comfort during the dying process?
For many people, CPR just prolongs the dying process, is this okay?

Conclusion:
The conversation about CPR and other end-of-life decisions is a journey of informing, understanding and helping to support the person who has the difficult choice to make. As professionals, we have to find the courage to walk with our patients as they move through their illness and toward death. As patients and family members, it is important to have these conversations early on and I would encourage everyone to ask for the answers and support you need. If the doctor won't talk to you, find a doctor who will. And if after talking with the doctor, you realize he won't respect or support the patient's wishes, find a doctor who will. Once you have made the decision, write it down and tell others what you would want. Don't make them guess.

A final thought: I am not saying that people shouldn't choose to attempt CPR; I just want to make sure patients and their loved ones have the facts about what is CPR, the chance of it working, the kind of condition the person might be in after CPR and the kind of death that is being chosen. Make wise and informed decisions for yourself and for those in your care. Have a kind and respectful day.

Study Questions:
What are the common misunderstandings about CPR?
When talking about DNR, what other issues should be discussed?
What do you think would get in the way of you making a good decision for your loved one?
What decision would you make regarding CPR/DNR and how does that affect how you interact with those you serve?

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