

# Resuscitation decisions at the end of life : the final decisions

*Dr. Raymond Lo & Dr. Au Kar Ming*

*Palliative Care Unit*

*Department of Medicine and Geriatrics / Shatin Hospital*

Resuscitation decisions at the end of life often involve complex decision-making. They are important final decisions for patients, families and staff. Three cases were presented in the meeting, which illustrate that resuscitation decisions are best understood not in isolation, but within a broader context including patient values, cultural traditions, social relationships and spiritual relationships.

## **What resuscitation decisions are involved**

The ultimate resuscitation decision would be whether the patient should receive cardiopulmonary resuscitation when cardiac arrest develops. However, other significant resuscitation decisions also need to be made during the course of the illness trajectory. Should the patient receive any active treatment, ranging from another course of antibiotics, to inotropic or ventilatory support? Should the patient receive tube feeding? Should the patient be transferred back to acute hospital?

## **Whose decisions should it be?**

Are these purely doctors' decisions? Or should they be a team decision? How about patients' autonomy and own decisions? How about families and significant others' decisions? Finally if patient is cognitively impaired and no immediate next of kin is available, should guardianship board and court decisions be involved? Ideally, the best situation would be a decision which can be agreed by doctor, patient and family. However occasionally different parties may have different value judgements and expectations. An unanimous decision may not always be reached.

## **When to make decisions?**

When should discussions with patients and relatives be initiated? Should they be started early on admission, or should they be left until the final stages and impending death? There are several advantages in starting the communication process and making decisions earlier rather than later:

1. Any patients/families' misunderstanding of diagnosis, prognosis, and other issues on death and dying, fear or spirituality issues could be identified early;
2. Early discussion can allow enough time for patients and relatives to contemplate if necessary;
3. Early decisions are useful in case of unexpected decline or sudden arrest

There might be problems with leaving the decisions right till the end. Patients might not be cognitively competent then; relatives might not be contactable at short notice; patients and relatives might not be emotionally stable to make rational judgement; and the “end” would not be easily predictable.

### **Why making the decisions?**

The fundamental reason is that patients’ autonomy should be respected: they have the right to a “good death”. The focus of palliative care should be clearly explained. Prolonged suffering in the dying phase should be avoided, and futile treatment should be withheld. Unnecessary use of resources can be limited, and mental trauma of interventions or CPR to families or staff can be avoided.

### **Benefit and burden on making decisions**

The most obvious benefit would be that patients and relatives are empowered to make their own decisions on life and death issues. A sense of control can hence be gained, and fear of uncertainty of what may be done to them during the final moments can be alleviated.

However good communication skill is a pre-requisite in discussions on resuscitation issues. Sometimes despite adequate explanation and support, patients are not ready to decide or genuinely cannot decide. Patients may rather trust the decisions to doctors and families. They worry about inability to envisage the future. Relatives may also not be able to decide. They may not feel comfortable with the responsibility of decisions. Conflict of opinions may arise amongst different relatives.

### **Meanings and implications of decisions**

Resuscitation decisions would not just hinge on the physiological futility of the interventions, but would also be affected by the patients, relatives, and staff own value judgments. The decisions would depend on the perception of the desirable quality of life, quality of death and the sanctity of life. It could be that patients may overcome distress and see through the meaning of suffering, value every minute of their lives and cherish every opportunity to live. Relatives may also have every good reason to extend their loved ones’ life as long as possible, through which they satisfy their conscience in trying their best, allow time for last minute reunion with other close relatives, and are better coped with facing grief and bereavement.

### **Social and cultural influences on decisions**

Experience from UK seems to suggest that “majority of elderly welcome discussion of resuscitation and prefer this to be initiated by doctors. Many wish to decide themselves.”<sup>1</sup> Experience from US suggest that older patients prefer comfort care to treatment in extending life (61% of elderly vs 46% of middle aged  $p=0.04$ ), and have a tendency to opt for no CPR (48% of elderly vs 38% of middle aged,  $p=0.07$ ).<sup>2</sup> Interestingly though, 70.8 % and 78% of elderly patients in two US studies respectively, prefer to have their family and physician to take over the resuscitation decisions, and overrule their previous stated preferences if necessary, should they lose decision making capacity.<sup>3</sup>

A local study from Shatin Hospital showed that for a sample of 100 consecutive palliative care admissions, not for CPR decisions can be made by either patients or relatives for all the 100 cases. Male patients were more likely to make decisions than female. Excluding the patients with cognitive impairment, communication problems or critically ill conditions precluding communication, 63% of elderly patients can make their own decisions not for CPR. These findings helped clear the myths that Chinese elderly were incapable of making their own resuscitation decisions, although it is accepted that a potential barrier of taboo on talking about death may still exist for some.

### **Professionals’ viewpoint on CPR decisions**

British Medical Association and Royal College of Nursing guidelines in 1993 stated that CPR must be initiated in the event of a cardiac or pulmonary arrest in the absence of a DNR order,

or when the expressed wishes were not known.<sup>4</sup> However since then, considerable concern have arisen, either in that resuscitation status were not recorded, decisions were inappropriate, and very few patients or families were involved in DNR decisions.<sup>5,6,7</sup>

For patients receiving palliative care, the general consensus amongst professionals is that there is no obligation to offer, begin, or maintain interventions which are futile. In general, CPR should be withheld if patient refuses in advance and if burden much outweighs the benefit. But is CPR ever inappropriate in palliative care?<sup>8</sup> The National Council for Hospice and Specialist Palliative Care Services and the Association of Palliative Medicine stated that CPR should be considered if its success would probably result in a QOL acceptable to the patient.<sup>9</sup> Relevance of CPR in palliative care probably cannot be dismissed too rapidly.<sup>10</sup> Resuscitation may be justifiable if the patient and family need that extra time to achieve important personal goals. The utility and futility of particular resuscitation intervention should require consideration of patient as a whole. Involving patients and relatives in CPR discussions is necessary and appropriate, especially if there is uncertainty about futility.

## Conclusions

Resuscitation decisions at the end of life pose important clinical and ethical questions. Health professionals, especially palliative care professionals, should rise to the challenges, acknowledge, confront and debate the issues.

## References:

1. Bruce-Jones PN. Resuscitation decisions in the elderly: a discussion of current thinking. *J Med Ethics* 1996; 22(5): 286-291.
2. Rose JH, O'Toole EE, Dawson NV, Thomas C. Patient preferences for non-aggressive care, discussion about hospice and survival among hospitalised middle-aged and older cancer patients. *J Am Geriatr Soc* 2001; 49(4): S107-S108. (abstract).
3. Puchalski CM, Zhong ZS, Jacobs MM et al. Patients who want their family and physician to make resuscitation decisions for them: observations from SUPPORT and HELP. *J Am Geriatr Soc* 2000; 48(5): S 84-S90 (abstract).
4. British Medical Association/Royal College of Nursing Resuscitation Council. *Decisions relating to cardiopulmonary resuscitation*. London: BMA, 1993.
5. Davies P. Resuscitation decisions are often not documented early enough. *BMJ* 2000. 320: 1275 (letter).
6. Hignett CL, Forsyth DR, Connor GD. Improving the documentation and appropriateness of cardiopulmonary resuscitation decisions. *J Royal Soc Med* 1995; 88(3): 136-140.
7. Dautzenberg PL, Duursma SA, Bezemer PD et al. Resuscitation decisions on a Dutch geriatric ward. *Quarter J Med* 1993; 86(8):535-542.
8. Willard C. Cardiopulmonary resuscitation for palliative care patients: a discussion of ethical issues. *Palliat Med* 2000; 14: 308-312.
9. National Council for Hospice and Specialist Palliative Care Services and the Association of Palliative Medicine. CPR for people who are terminally ill. *Eur J Palliat Care* 1997; 4: 125
10. Rawlinson F. Cardiopulmonary resuscitation in Wales. *Palliat Med* 2000;14:75-78.