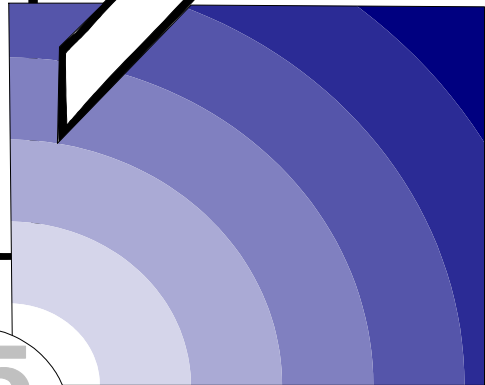
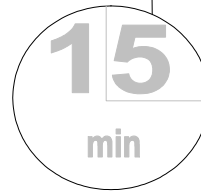


CLIP

15 minute Worksheet



Helping patients with symptoms other than pain

11: Issues around resuscitation

Intermediate level

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Aim of this worksheet

To review the issues around resuscitation and consider when not to attempt resuscitation

How to use this worksheet

- You can work through this worksheet by yourself, or with a tutor.
- Read the case study below, then work on the questions overleaf.
- The work page is on the right side, the information page is on the left.
- Work any way you want: you can try answering from your own knowledge (in which case fold over the information page), you can use the information page (this is not cheating- you learn as you find the information), or you can use other sources of information
- It should take you about 15 minutes. If anything is unclear, discuss it with a colleague.
- If you think any information is wrong or out of date let us know
- Take this learning into your workplace using the activity on the back page.

Case study

John is a 54 year old man who had surgery for a carcinoma of the colon. He has been deteriorating steadily and is now reaching the end stages of his disease. He has become increasingly disorientated, chesty and sleepy over the past week. The clinical team agree that he is within days of death as a result of his cancer. The doctor on the team feels that John is not for resuscitation and is adamant that John's wife must be asked for permission not to resuscitate John. On this basis the doctor has stopped John's antibiotics that were started for his chest.

v8

What is resuscitation?

Over the past few years publicised cases of treatment withdrawal have demonstrated that different clinicians define resuscitation in different ways. In the context of palliative care (the care of people with progressive life-threatening illness), resuscitation is clearer:

These are resuscitation measures: cardiac massage, artificial respiration. These cardiopulmonary resuscitation (CPR) measures will be instituted by local staff, but would precipitate calling emergency services and admission to an acute hospital.

These are comfort and palliative treatment measures: Analgesia, antibiotics, drugs for symptom control, feeding (any route), hydration (any route), oxygen, hospital admission for investigation and treatment of a reversible condition, seizure control, suction, treatment for choking. These measures would involve discussion and consideration as to their need.

When guidelines do not exist or are unclear, it is common for clinicians and carers to confuse the two types of measures. In palliative care there is little confusion between these two types of measures:

- CPR is instituted immediately and in full following an *unexpected* collapse, and if there is a reasonable chance of success.
- Comfort and treatment measures are instituted after assessment, consultation with patient and family, and on the basis of clinical need.

Who decides about resuscitation?

Ideally this results from a consensus between the patient and the clinical team. With the patient's permission, this consensus should include the partner and relatives. Occasionally the patient does not want the partner or relatives to be involved in discussions about resuscitation, in which case the patient's wishes should be respected.

When a patient like John is unable to take part in the decision, the clinical team must act in John's best interests. The partner or relatives must be asked if they are aware of John's previous views on resuscitation, and they must be kept informed of decisions, but they have no legal right to decide on John's behalf.

In the terminal stage of progressive conditions such as cancer or motor neurone disease, death is an *expected*, inevitable result of the underlying disease. In this situation, the clinical team can be 'as certain as it can be' that resuscitation would fail. Here there is no treatment decision to be made. Discussing a treatment that cannot be offered (because it would fail) causes unnecessary distress and burden on the patient, partner or relative. However, there is a need to be as open about the facts as the patient, partner and family feel able to discuss at the time (see CliP Worksheet on *Breaking Difficult News*).

MCQ answers: 1) T 2) F 3) F 4) T 5) F

What is DNAR and how do you make decisions about DNAR?

This stands for 'Do Not Attempt Resuscitation'

-it replaces terms such as 'Not for CPR', 'Not for Resuscitation' or 'Not for 350, 999' etc.

Decisions and actions

Decide on the competency of the patient: competent patients are able to understand their situation and the consequences of their decisions, are free from depression (a clinical diagnosis which is usually treatable), and are not under the influence of others (eg. pressure from a dominant person on a passive patient). If a person is not competent for this decision, the clinical team must make a decision based on information of the patients previous wishes. The partner or relatives can be very helpful in providing such information.

Consider which of the following 3 situations apply:

- 1) *The circumstances of the future arrest cannot be anticipated:* in this situation no decision can be made that would help the clinical team. If the patient arrests unexpectedly, carry out CPR if there is a reasonable possibility of success.
- 2) *The person is dying naturally of their disease:* CPR would not help the patient, so there is no need to burden the patient or family with any decision, although they must be given as much information as they want at the time. The aim is to 'Allow Natural Death' (AND) while providing comfort and dignity with effective palliative care.
- 3) *The circumstances of an arrest can be anticipated* (eg. following previous life-threatening events): in this situation discuss with the patient what they would want in the future .

In all cases, *keep the patient, partner and family informed* of the situation with information given at their pace.

There cannot be a 'default' position regarding DNAR: an unexpected arrest must be assessed by the clinical team at the time.

Document decision in notes. Keep a DNAR order in front of the notes. Send a copy of the form to key clinical staff. Regularly review the need for resuscitation (while this does not mean burdening the patient and family with a DNAR decision every day, it does require staff to be sensitive in picking up any change of views during discussions with the patient, partner or family). Any change in decision needs a new DNAR form.

When consensus is difficult to achieve

On occasions the decision is not unanimous and has to be made by a majority view. When one or two members of the team hold a minority view, the rest of the team should respect their view and be prepared to review the situation after a time period agreed by the whole team. Staff or family with continuing concerns should approach the senior nurse and doctor for discussion. Staff who still have concerns should approach their line manager. Staff and family who still feel dissatisfied should contact the Chief Executive of their organisation who has responsibility for clinical governance. The chair of the local ethics committee can offer advice on further action.

Courts may be approached for the final say. This is usually a last resort, although courts can be helpful in deciding complex cases.

Reflect

Think briefly about the doctor's wish to ask John's wife for permission not to resuscitate, and the doctor's decision to stop antibiotics
Do you agree, disagree or are you unsure?

Write

Ring those words below you think are covered by the term 'resuscitation'

- | | | |
|------------------------|-------------------|---------------------------|
| antibiotics | hydration | heart massage |
| feeding | controlling a fit | oxygen for breathlessness |
| artificial respiration | analgesics | suction |

MCQ

- | | | |
|--|------|-------|
| 1. Relatives have no legal right to decide on John's behalf | True | False |
| 2. Where death is expected, the patient and relative must be asked for permission not to resuscitate | True | False |
| 3. If a decision is made not to resuscitate, then anything which might prolong life must also be stopped (eg. antibiotics) | True | False |
| 4. Decisions about resuscitation can change | True | False |
| 5. Decisions about resuscitation must be unanimous | True | False |

Reflect

Think about what could be done in these situations

| Situation | Possible solution(s) |
|--|----------------------|
| John's wife makes it clear she <i>does</i> want resuscitation | |
| John improves and is becomes mentally clear | |
| The rest of the clinical team feel the antibiotics should continue | |
| John suddenly chokes on some food and stops breathing | |

Reflect

What do you think about John's situation now?

FURTHER ACTIVITY: Issues around resuscitation

Find out what your resuscitation policy says in your clinical setting

–does it address the issues of people with advanced disease?

FURTHER READING: Issues around resuscitation

Key documentation

British Medical Association. *The Impact of the Human Rights Act 1998 on Medical Decision Making*. London: BMA, October 2000.

British Medical Association. *Withholding or Withdrawing life-prolonging medical treatment, 2nd ed.*. London: BMA Books, 2001.

(Second edition available in full on www.bmj.com/withwith/ww.htm)

Decisions relating to cardiopulmonary Resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. *Journal of Medical Ethics*, 2001; **27**: 310-6 (September 2001)

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(Available in full in Guidelines section on www.bma.org.uk)

Mencap. Considerations of 'quality of life' in cases of medical decision making for individuals with severe learning disabilities. *Mencap*, 2001 (summary available on www.mencap.org.uk/html/campaigns/health_pubs.htm)

Randall F. Recent guidance on resuscitation: patients' choices and doctors' duties. *Palliative Medicine*, 2002; **15**: 449-50.

Other sources

Cardiopulmonary resuscitation (CPR) training and risk management strategy. Health and Safety Policy no 4, Newcastle Hospitals NHS Trust. April 1999.

Dautzenberg PLJ, Brookman TC, Hooyer C. Review: patient-related predictors of cardiopulmonary resuscitation of hospitalised patients. *Age and Ageing* 1993; **22**: 464 – 475.

Ebell MH. Pre-arrest predictors of survival following in-hospital cardiopulmonary resuscitation: comparison of two predictive instruments. *Resuscitation*, 1994; **28**: 21-25.

Elwell L. The no-CPR decision: the ideal and the reality. *Journal of Palliative Care* 2000; **16**: 53 – 56.

Ethical decision-making in palliative care: cardiopulmonary resuscitation (CPR) for people who are terminally ill. Joint working party between the National Council for specialist palliative care services and the ethics committee of the Association for Palliative Medicine of Great Britain and Ireland, August 1997.

George AL, Folk BP, Crecelius PL. Pre-arrest morbidity and other correlates of survival after in-hospital cardiopulmonary arrest. *American Journal of Medicine* 1989; **87**: 28 –34.

Murphy DJ, Burrows D, Santilli S. The influence of the probability of survival on patients' preferences regarding cardiopulmonary resuscitation. *New England Journal of Medicine*, 1994; **330**: 545 – 549.

Smith S. The role of the court in ethical decision making. *Clinical Medicine (Journal of the Royal College of Physicians of London)*, 2001; **5**:371-3.

Willard C. Cardiopulmonary resuscitation for palliative care patients: a discussion of ethical issues. *Palliative Medicine*, 2000; **14**: 308 – 312.

Further information resources

National Council for Hospice and Specialist Palliative Care Services: www.hospice-spc-council.org.uk/index.htm

Resuscitation Council: www.resus.org.uk

Royal College of Paediatrics and Child Health: www.rcpch.ac.uk/rcpch

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Current Learning In Palliative care
An accessible learning programme for health care professionals

Fifty seven 15 minute worksheets are available on:

- An introduction to palliative care (3 worksheets)
- Helping the patient with pain (9 worksheets)
- Helping the patient with symptoms other than pain (11 worksheets)
- Moving the ill patient (2 worksheets)
- Psychological needs (8 worksheets)
- Helping patients with reduced hydration and nutrition (8 worksheets)
- Procedures in palliative care (4 worksheets)
- Understanding and helping the person with alternative communication (learning disabilities) (5 worksheets)
- The last hours and days (4 worksheets)
- Bereavement (3 worksheets)

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Helping the Patient with Advanced Disease: a Workbook. Regnard C. ed.

Oxford: Radcliffe Medical Press www.radcliffe-oxford.com