Conflicting Perspectives Compromising Discussions on Cardiopulmonary Resuscitation

J Groarke, J Gallagher, R McGovern
Department of Medicine, St Luke’s General Hospital, Kilkenny

Abstract
Healthcare professionals, patients and their relatives are expected to discuss resuscitation together. This study aims to identify the differences in the knowledge base and understanding of these parties. Questionnaires examining knowledge and opinion on resuscitation matters were completed during interviews of randomly selected doctors, nurses and the general public. 70% doctors, 24% nurses and 0% of a public group correctly estimated survival to discharge following in-hospital resuscitation attempts. Deficiencies were identified in doctor and nurse knowledge of ethics governing resuscitation decisions. Public opinion often conflicts with ethical guidelines. Public understanding of the nature of cardiopulmonary arrests and resuscitation attempts; and of the implications of a Do Not Attempt Resuscitation (DNAR) order is poor. Television medical dramas are the primary source of resuscitation knowledge. Deficiencies in healthcare professionals' knowledge of resuscitation ethics and outcomes may compromise resuscitation decisions. Educational initiatives to address deficiencies are necessary. Parties involved in discussion on resuscitation do not share the same knowledge base reducing the likelihood of meaningful discussion. Public misapprehensions surrounding resuscitation must be identified and corrected during discussion.

Introduction
Only 16% of patients resuscitated following an in-hospital cardiopulmonary arrest will survive to discharge. The majority (45-86.4%) of patients demonstrate physiological decline in the period that precedes an in-hospital cardiac arrest. Recognising this pre-arrest decline should provide a timely opportunity for doctors to consider resuscitation status of patients. Health professionals can be reluctant to discuss the resuscitation decision with patients. It is important to ensure patients most likely to benefit from these interventions are resuscitated and to avoid futile resuscitation attempts that disrupt the natural dying process of other patients. In general, the doctor and the adult patient will discuss the option of resuscitation in the event of a cardiopulmonary arrest and decide on resuscitation status. The family may or may not be involved. In the case of an adult patient lacking capacity, the doctor will often discuss resuscitation with those closest to the patient. This study aims to highlight the differing perspectives and understandings of the groups involved in resuscitation discussions.

Methods
An observational study was carried out to examine the knowledge and opinions of doctors, nurses and the general public on various aspects of resuscitation. Doctors were randomly selected from the fields of medicine and surgery only. Nurses were randomly selected from general medical, general surgical, coronary care and intensive care wards. Individuals that had worked in the healthcare services were excluded from the randomly selected general public group. A questionnaire with a selection of multiple choice and closed questions was designed for each study group and were completed during face-to-face interviews by a single interviewer. Questions examined personal opinion as well as factual and ethical knowledge of hospital resuscitation attempts.

Results
Baseline characteristics of each group are outlined in Table 1. 70% of doctors, only 24% of nurses and no person form the general public group correctly estimated survival to discharge after in-hospital cardiopulmonary resuscitation attempts at less than 20%. The remaining percentages of each group overestimated survival. 78% of those doctors who over-estimated survival were of house officer grade. Figure 1 outlines the breakdown of estimates of survival to discharge by group.

Health professionals understanding of ethical and legal guidelines governing resuscitation decisions was examined. 47% of doctors and 40% of nurses incorrectly deem decisions on resuscitation made by a doctor in the best interest of an adult patient incapable of decision making (where no other person has the legal authority to make decisions on the patients behalf) as invalid if not discussed with the patients family. In the setting of intra-family disagreement regarding the resuscitation status of an incompetent adult relative, 30% of doctors and 25% of nurses incorrectly believe that the final decision rests with the majority rule of the family rather than with the patients doctor. In the event of a family disagreeing with a doctors decision on resuscitation status of an incompetent relative, only 63% of doctors interviewed correctly recognise seeking an independent second medical opinion as most appropriate - 27% believe that the doctors decision is final and 10% believe the family decision is final. A greater percentage of nurses (84%) identified a second medical opinion as the most appropriate option. 38% of doctors and 76% of nurses believe resuscitation decisions are made too infrequently. 13% of doctors and all nurses interviewed incorrectly believe that patients can issue a directive demanding a resuscitation attempt.

Figure 1: Estimates of each study group on survival to discharge following an in-hospital cardiopulmonary resuscitation effort

Questions examined the publics understanding of cardiopulmonary arrests and of the nature of resuscitation attempts. 67% incorrectly equate a cardiac arrest to a heart attack. Only 33% considered the cessation of heart beat and/or respiratory effort as components of a cardiac arrest.
arrest. 42% did not think that resuscitation attempts would involve the use of drugs or tracheal intubation. 58% of the public interviewed report television medical dramas as their primary source of information on resuscitation attempts. Half believe that these medical dramas provide an accurate portrayal of resuscitation attempts. The publics understanding of a Do Not Attempt Resuscitation (DNAR) order was examined. 58% believe that all forms of treatment stop for a patient with such an order in place and 64% believe that a DNAR order will cancel any further blood or other investigations. 75% expressed a desire to be involved in resuscitation decisions both involving a loved one and themselves. 40% of the general public interviewed believe that the family, and not the doctor, have the final say on the resuscitation status of relatives incapable of decision making (in cases where no other person has legal authority to make decisions on the patients behalf). Although no person from this group correctly estimated survival, 73% believe that they possess sufficient understanding to facilitate a comfortable contribution to such decision making. The same number would want to read a patient information leaflet if involved in such a decision.

Discussion
CPR was developed with the intention of reversing premature cardiopulmonary arrest in patients. Ethically, it is imperative that the responsibility of the doctor to take care that the sick patient dies with dignity and with as little suffering as possible. In these circumstances a doctor is not obliged to initiate or maintain a treatment which is futile or disproportionately burdensome 6. The Irish Supreme Court recognises the right to a natural death as being part of the right to life under the Constitution 7. The European Convention on Human Rights recognises an individuals right to be free from inhuman or degrading treatment (Article 3). Therefore, failure to protect patients for whom a cardiopulmonary arrest is an appropriate, timely terminal event from futile resuscitation attempts can be considered unlawful and unethical. A general reluctance to discuss resuscitation is often demonstrated by healthcare professionals.

Clear ethical guidelines govern discussions and decisions on resuscitation status and advance directives. This study highlights poor knowledge among healthcare professionals of the relevant ethics and that public opinion often conflicts with these guidelines. An adult patient capable of decision making has the right to refuse treatment. Advance directives are usually confined to a refusal of future treatment. An advance directive demanding a particular treatment would not be binding on medical staff. However, some doctors (13%) and all nurses interviewed believed that a patient incapable of giving a valid decision a refusal of treatment was being binding. Patients and/or relatives understanding and expectations of resuscitation efforts should be explored during discussions. Television medical dramas, a principal source of the publics knowledge of resuscitation matters, portray an exaggerated survival to discharge of 67% following in-hospital resuscitation attempts. The exact nature of a resuscitation attempt and when it is indicated should be explained. Possible complications of resuscitation efforts need to be explained. The doctor must confirm their understanding and clarify any uncertainties. As junior doctors demonstrated a poorer understanding of resuscitation survival and ethics than their senior colleagues, discussions should be lead by the most senior doctor available.

Involving the family in the discussion or informing them of the decision made can only be done with the patients consent. In the case of an adult who is incapable of decision making with no advance directive in place and where no other person has legal authority to make decisions on the patients behalf, the doctor has the authority to act in the best interest of the patient. The doctor should explain to the family that their views on what the patient would most likely have wanted (rather than what they want for the patient) are important and will be considered in the decision. They should understand their role is not to take decisions on behalf of the patient but to participate in discussions between the relevant parties. AAdvance directives should ensure a mutual consensus on a decision that best serves the patient. Where there is disagreement, further discussion should aim at securing an understanding and acceptance of the clinical judgement. If disagreement persists, a second opinion should be sought from a suitably qualified and independent medical practitioner. Not all doctors interviewed in this study appreciated the need for a second medical opinion in such circumstances.

The overall clinical responsibility for decisions about CPR, including DNAR decisions, rests with the most senior clinician in charge of the patients care. In the Republic of Ireland this is the most senior doctor caring for the patient. In the United Kingdom, the most senior clinician could be a consultant, general practitioner or, as of October 2007, a suitably experienced nurse. Training to address the knowledge deficits among doctors and nurses highlighted by this study should be the priority in the Republic of Ireland. Any such change in policy to extend decision making responsibilities to nurses in this country must be accompanied by adequate training. Strategies to ensure the quality of DNAR decisions being made need to be explored. Patients and their relatives have a poor understanding of what resuscitation attempts involve and the documentation is difficult to understand. The largest source of public knowledge on resuscitation is the television which does not accurately reflect reality. Parties must be educated during discussions to facilitate their meaningful informed contribution. A better mutual understanding between the parties involved will increase the likelihood of arriving at a consensus that best serves the patient. Information leaflets on this topic should be made available in every hospital.

In summary, the knowledge bases of parties involved in resuscitation discussions differ significantly. The general public significantly overestimate the success of CPR attempts while nurses and doctors also do so, but to a lesser extent. There is a significant difference between healthcare professionals views on resuscitation and the views of the public. However, these differences and misapprehensions are often not appreciated or addressed in discussions on resuscitation status. Such conflicting perspectives compromise resuscitation discussions. There is a poor understanding of the ethics governing resuscitation decisions among healthcare professionals and these ethics often conflict with public opinion. Doctors and nurses must be definite on the ethics involved in embarking on resuscitation discussions. Doctors can be deficient in initiating resuscitation discussions and decisions. Training in areas such as survival, ethics, and communication is needed. Failure to address these deficiencies will violate an ethical and legal responsibility to ensure patients a dignified and comfortable death.

Conflicting Perspectives Compromising Discussions on Cardiopulmonary Resuscitation
References

12. Irish Medical Council, Guide to Ethical Conduct and Behaviour (Seventh Edition 2009)-34.6
14. The Irish Medical Council, Guide to Ethical Conduct and Behaviour (Sixth Edition). 22.1
15. Decisions relating to Cardiopulmonary Resuscitation. A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. October 2007

Comments:

Conflicting Perspectives Compromising Discussions on Cardiopulmonary Resuscitation

Conversational: J. Groarke
Department of Medicine, St Luke’s General Hospital, Kilkenny
Email: johngroarke1@eircom.net