Should patients who are at the end of life be offered resuscitation?

A REQUEST FOR RESUSCITATION
Mrs Baker, aged 45, has pancreatic cancer and has received palliative chemotherapy but is deteriorating rapidly. She lives with her husband and he wants her to stay at home. They have no children.

The district nurse visits and decides that Mrs Baker is in the last few days of life. The nurse has a good relationship with Mrs Baker and her husband and has been able to talk openly with her about her disease and her future. Mrs Baker acknowledges that she is deteriorating quickly, and has only days left to live.

The nurse explains the aims of care and that ‘we will not do anything heroic’. Mrs Baker asks what this means. The nurse explains that when she dies it would not be appropriate to carry out cardiopulmonary resuscitation. Mrs Baker is adamant that although she is dying, she wants to be resuscitated so that she can see a close friend who is planning to visit.

Discussion
The issue here is whether it is appropriate to open a discussion on CPR with a patient in the last days of life. Resuscitation is intended to treat sudden and unexpected cardiac or respiratory arrest. It is important at the end of life to diagnose when someone is dying and ensure they are not given false hope by offering an inappropriate intervention such as CPR.

The Patient’s Charter (1991), Mental Capacity Act 2005 and the End of Life Care Strategy (2008) all emphasise the importance of patient choice in medical decisions. Problems can occur when patients are presented with choices or make a decision that is not in their best interest.

Resuscitation guidelines from the BMA et al (2007) state that if a person has a cardiac or respiratory arrest and CPR is unlikely to succeed it must not be attempted. However, they also state that if a patient is adamant they want to be resuscitated – even when medical assessment suggests it is likely to be futile – the patient’s choice should be followed, although at the time of the arrest the decision should be reviewed. This appears to suggest we should pretend to go along with patients’ wishes but at the point of arrest overrule their request.

Ewer et al (2001) looked at the success rates of CPR involving patients where an arrest was expected, but as part of the dying process, and those for whom it was unexpected. The rate of success for the unexpected arrests was 22%, but for expected arrest in patients at the end of life, success was 0%.

If an arrest is considered to be an expected part of dying at the end of life CPR is not appropriate. The consequence of inappropriate CPR is an undignified death, distress to relatives, demoralisation of healthcare staff and poor use of resources.

So, what should the nurse have done? She was right to talk to Mrs Baker about her condition but it may not have been appropriate to discuss CPR at this point. An explanation that the aim of care was to promote Mrs Baker’s comfort may have been more appropriate. It may have helped if the issue of end-of-life care and CPR had been discussed earlier in Mrs Baker’s illness.

The final decision on CPR is made by the senior clinician (the GP, palliative care consultant, nurse consultant), according to local policy and the nurse should discuss the situation with them.

The nurse could have started Mrs Baker on the Liverpool Care Pathway (LCP), if this has been adopted locally. This tool can help professionals to make an accurate diagnosis of dying (Ellershaw and Ward, 2003) and may have helped to facilitate discussion around end-of-life issues at an appropriate time in Mrs Baker’s illness. Excellent communication between the multiprofessional team is essential when CPR is being discussed. It is important that patients receive consistent information that helps them to understand why CPR is not appropriate and the consequences of intervening in this way. Patients must never be offered treatment or interventions that are inappropriate and should not be given choices that have little chance of success.

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Next week’s in-depth article discusses resuscitation at the end of life in greater detail.

REFERENCES

Have you been involved in a new treatment or therapy?
Have you been involved in a situation that has made you think about or change your practice?
If you or your colleagues would like to share your experience email your ideas to NT@emap.com, putting ‘Case studies’ in the subject box.