

## The resuscitation conversation

"I want to be resuscitated but I don't want to be on machines."  
"Do you want us to do everything for your father?"

**H**aving conversations about whether to attempt cardiopulmonary resuscitation (CPR) is complex, as illustrated by the ambiguity of the two statements above. CPR was first trialed in the early 1960s on postoperative patients who were likely temporarily medically unstable, and the results were very encouraging.<sup>1</sup> After a short time and in a climate of medical optimism, this procedure was offered to everyone in the hospital and community regardless of medical condition.<sup>2</sup> But by the mid-1970s doctors were aware of its limited usefulness and began to advocate for the right of the patient to refuse resuscitation.<sup>3</sup> This movement, backed by increasing patient autonomy in decision making, seems to have gradually changed the way the public and health care providers view CPR. Rather than still being considered a medical procedure with its indications, adverse effects, and outcomes all considered, it has become part of the continuum of choice for patients and their substitute decision-makers.<sup>4</sup>

It is quite clear that the outcomes with CPR are dismal for patients with advanced illness, particularly those with multiple comorbidities, and even if successful these patients will not be improved beyond their condition prior to arrest. This is often not understood by patients and their decision-makers, who have inaccurate knowledge of CPR and its effectiveness and outcomes.<sup>5</sup> A qualitative study of patients and decision-makers following resuscitation discussions revealed that a number of participants understood CPR and "being revived" as something different from being on life support.<sup>6</sup>

The resuscitation conversation gets more complicated when the patient doesn't have capacity and has not made his or her preferences known to a substitute decision-maker. Substitute decision-makers can predict the preferences of their loved ones only 68% of the time, according to a meta-analysis of patient/surrogate preference comparisons,<sup>7</sup> and it is also known that patient preferences change over time.<sup>8</sup>

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A recent paper analyzed the difference between surrogate and patient preferences and found it could be attributed mostly to the wishes of the surrogate.<sup>9</sup> However, another study did show that patients wish to have both family and health care professionals involved in the decision-making process.<sup>10</sup>

Shared decision making has generally been thought of as the gold standard for complex decisions. This process has been defined as "a collaborative endeavor in which patient and physician share not only information and intuitions but the making of deci-

sions."<sup>11</sup> Shared decision making includes a mutual understanding of the problem and options available, the pros and cons of the options, the patient goals and preferences, a clinician recommendation, and lastly, the jointly made decision.

A study of physicians involved in end-of-life decision-making shows they play four distinct roles: informative (medical information only, no elicitation of patient goals, no recommendation); facilitative (medical information, patient goals discussed, no recommendations); collaborative (shared-decision making); and directive (physician-made decision alone and informed patient).<sup>12</sup> The majority of the interactions were collaborative and facilitative with the other two roles being outliers.

Decision making at end of life is becoming increasingly complex as medicine evolves therapies to prolong life and there are more options to weigh. Making decisions about another person's care with information that may not be fully understood and complexities of illness and prognosis that are challenging even for those who work daily in the area may result in poor decisions or decisions that result in care that could be reasonably seen as medically futile.<sup>13</sup>

Increasingly, incapable patients with multiple comorbidities near the end of life have families requesting CPR. What may lie behind this request is not necessarily the wishes of the individual, but fear and denial of death or community peer pressure about duty to show care for a loved one. Physicians need to take the shared decision-making steps of ensuring mutual understanding of all options,

particularly the no CPR option, where the health care team continues to care for the patient to allow him or her to live as well and as long as possible until death comes peacefully. It should be explained that CPR will, at best, only return the patient to his or her current condition and that there is less than 5% chance of that happening. Physicians also need to make recommendations to patients and families, using language that is clear and that avoids medical jargon.

A case can be made for the physician to decide not to offer resuscitation to a patient with advanced illness as part of reasonable medical practice, even if the family requests it.<sup>14</sup> It is important for our society to have public conversations about the limits of medicine and the limits of autonomy and for doctors to be part of these conversations.

Like it or not, physicians are stewards of health care resources. If we are going to make rational and just use of the therapies we have, we need to give clear information and recommendations to patients and families about futile medical therapies.<sup>15</sup> We make recommendations about treatment throughout the course of an illness. Let's not abandon patients and families when it comes to end-of-life decision making.

—**Romayne Gallagher, MD**  
 —**Janet McElhaney, MD**  
**Co-chairs, Geriatrics and Palliative Care Committee**

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particularly with such an old and unique system. But this way, the clinic was able to be up and running on day one without having to constantly refer to two systems and run the risk of missing important information, as observed by Dr Les Bradley: “It is not easy to migrate from one EMR to another because you are out of your comfort zone. Although it is tempting, never use two EMRs at the same time.”

While the staff and some of the physicians are happy with the change, Dr Bradley, who started out in Nanaimo in July 1970 and was involved in the first EMR installation, finds it hard to get used to typing all the data himself. “With the old system the clinic used stenographers to put the patient information into the computer. With the new system I have to type in everything. It’s like getting remarried,” he says.

Dr Bradley believes that the move from paper to an electronic system is easier than the transition from one EMR to another, a comment made by many who have converted to EMR and later changed EMRs.

“It’s easier because you have no burnt-in EMR reflexes,” Dr Bradley explains. “It’s like when the power is out and you know it, but you still try to switch on the lights when you go into a room. I have to stop doing that.”

The transition to the modern electronic system has already helped the clinic save time and money and reduce the environmental impact. “This process has cut down tremendously on printing of day sheets and encounter forms, so we are saving trees in the new process, too. We have great staff and physicians at the clinic, and because of their hard work and dedication to the new EMR, the transition has been successful,” Ms Gross says.

One of the benefits of the new electronic medical record system has been the ability to download the lab test results directly into the EMR. Physicians used to receive test results

in 3 or 4 days. Now the clinic gets the results on the same or next day. This not only saves time but allows the physician to contact the patient sooner, if necessary.

While it is still early days using full EMR functionality, the clinic is already starting to see the benefits. Dr Harry Latham observes, “It enhances the quality of care. You don’t have to sort through a bunch of papers, you don’t lose or misfile lab work or consultation letters, and you don’t have to run around looking for paper charts.”

### Plans for the future

Once the clinic has settled in with the new EMR, it looks forward to using more of the advanced functionality that the prior EMR didn’t have. Ms Gross says the clinic doesn’t plan to rest on its laurels. “Next we will be starting to use the chronic disease management tools such as flowsheets, recalls, and analytical tools, and then we look forward to using the template configuration tool to create templates for documentation and requisitions. This will allow us to really enhance our care of patients with chronic conditions and complex care requirements.”

The physicians at Caledonian Clinic would like to form a PITO Community of Practice in Nanaimo but they have held off until they get more used to the new EMR and until some of the remaining practices complete their implementations. In particular, Ms Gross wishes there were some improvements in the communication between GPs and specialists. “All the new PITO vendors could interface with each other. I would like to see patient records sent to a specialist when the patient is referred. This would save time and also would give the specialist the patient’s total EMR, which would initiate better patient care,” she says.

For more information on the Caledonian experience, see the full history and technical details under Case Studies at [www.pito.bc.ca](http://www.pito.bc.ca).

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