Southern Caregiver Resource Center

Caring for those who care for others

Fact Sheet: Advanced Illness: CPR & DNR

Big issues—and big decisions—confront us when we think about the imminent death of a terminally ill loved one in our care. Among the emotional, legal and financial considerations are also questions regarding the type of medical assistance your loved one should receive as their illness advances. For example, if your loved one suddenly has difficulty breathing, will you allow a paramedic or an emergency room technician to administer CPR? And if CPR revives your loved one, yet he or she still can no longer breathe on his or her own, should you allow a machine—a respirator—to breathe for him or her?

A better understanding of cardiopulmonary resuscitation, or CPR, can be helpful when it comes to making this difficult choice before a crisis occurs. This fact sheet specifically addresses the process of CPR and describes the DNR (Do Not Resuscitate) form, the legal document used to indicate to medical professionals your—or your loved one's—wishes. (For a more detailed discussion of the other issues involved in planning for the end of life, see the fact sheets *End-of-Life Decision Making*, and *Advanced Illness: CPR and DNR*).

CPR (Cardiopulmonary Resuscitation)

Consider the following scenario:

Nancy's husband has had Alzheimer's disease for eight years and is now in the final stages of the illness. After a discussion of end-of-life issues with her family, Nancy has decided to "let nature take its course" if anything of an urgent medical nature happens to her husband. In other words, she does not want him to be put on life support. She has told her doctor of this decision, and he has concurred.

One night, Nancy wakes up to find her husband having trouble breathing. Reflexively, without thinking, she calls 911. By the time the paramedics arrive, her husband has stopped breathing completely. The paramedics leap to do their job: they immediately administer CPR and take him to the hospital. By the time Nancy arrives at the hospital, her husband is connected to a ventilator and numerous IVs. Unfortunately, this is exactly what she did not want for him.

Definition

Fully understanding Nancy's scenario requires a deeper understanding of cardiopulmonary resuscitation. Simply put, CPR is the process of restarting the heartbeat and breathing after one or both has stopped. The first step involves creating an artificial heartbeat by pushing on the chest and attempting to restore breathing by blowing into the person's mouth. A medical professional will then insert a tube through the mouth and down the airway to make the artificial breathing more efficient. Electric shocks may be given to the heart, and various drugs may be given through an intravenous line. If the heartbeat starts again but breathing is still not adequate, a machine called a ventilator may be employed to move air in and out of the person's lungs indefinitely.

On television, CPR is often depicted as the ultimate life-saving technique. However, television does not show this process quite accurately—in real life, the process is more brutal. Pushing the center of the chest down about one and one-half inches, 100 times a minute for several minutes, causes pain, and may even break ribs, damage the liver, or create other significant problems. CPR produces a barely adequate heartbeat, and doing it more gently is not sufficient to circulate enough blood. Electric shocks and a tube in the throat are also harsh treatments, but may be essential to resuscitate someone.

CPR frequently can save a person's life, particularly in the case of some kinds of heart attacks and accidents an otherwise healthy person may experience. CPR is also most successful when the failure of heartbeat and breathing occurs in the hospital, in the Cardiac Care Unit (CCU). Nurses in the unit will instantly recognize the problem and begin sophisticated care.

However, when a person is in failing health from a serious and progressive illness, the heart and breathing will ultimately fail as a result of that illness. In such a circumstance, there is little chance that CPR will succeed at all. Any success will be temporary at best, because the person's weakened condition will soon cause the heartbeat and breathing to fail again.

Another possibility is that CPR may be only partially successful. If the heartbeat is restored but a person is still too weak to breathe on his or her own and remains too weak to do so, he or she may be on a ventilator for days, weeks, months or longer. Moreover, when breathing or heartbeat fails, the brain is rapidly deprived of oxygen. As a result, within seconds, the brain begins to fail (one loses consciousness), and within a very few minutes permanent damage to the brain occurs. If it takes more than those very few minutes to start effective CPR, the person will not fully recover. The brain damage may mean anything from some mental slowing and loss of memory to complete and permanent unconsciousness and dependency on a ventilator and sophisticated medical life support. (See fact sheet: *Advanced Illness: Feeding Tubes and Ventilators*.)

The Role of Emergency Help (Calling 911)

A call to 911 is a request for emergency help; the goal of those who respond to 911 calls is to protect life and property, and the people who respond expect to go to work doing what they are trained to do to accomplish that goal. If your house is on fire, the firefighters don't ask for permission to cut a hole in your roof and spray water all over your living room—they just do what is necessary to stop the fire from destroying your home.

Similarly, when a person's heartbeat and breathing have failed, the 911 responders are not prepared to have a long talk with you about the person's condition and what you think might be best to do. They know that any delay could mean brain damage, so they immediately start CPR and then take the person to the hospital. With one exception, which we will discuss in the next section, their rules require this, and it makes sense if you think about the purpose of the 911 system.

When Nancy called 911 in our scenario, the paramedics simply did what they are trained to do—they revived her husband. However, if Nancy and her doctor had completed a DNR form and kept it in the home, her husband would not have been resuscitated and/or connected to machines when he got to the hospital.

The Do Not Resuscitate (DNR) Form

The "Emergency Medical Systems Prehospital Do Not Resuscitate (DNR) Form" is a legal document that gives the 911 responders

permission not to perform CPR. The DNR form is prepared in advance of any situation and kept at home. This prehospital DNR form lists the name of the person to whom it applies and is signed by that person (or whoever represents that person if he or she is too ill to make medical decisions on his or her own behalf). It is also signed by the person's doctor. Please note this is very important: the form is not valid until the doctor signs it, as it a medical order. There is a new form, which can replace or be a supplement to the traditional DNR order called a POLST (Physician Orders for Life Sustaining Treatment). (See fact sheet: *End of Life Decision Making* for more information on POLST.

The DNR or POLST is the only form that affects 911 responders; other documents, such as a Durable Power of Attorney for Health Care or some other Advanced Directives, do not. If emergency personnel arrive to find a person whose heartbeat and breathing have failed or are failing, they will perform CPR unless they see a correctly completed DNR/ POLST.

In light of this, the DNR/ POLST form should be kept near the ill person's bed, perhaps on the wall, so it will be easy to find in case of emergency. When 911 responders see this form, they will still do anything they can to make the sick person comfortable, but they will not perform CPR. In the absence of a DNR/ POLST form, they *must* do CPR. The DNR/ POLST is the only form that gives you control over what they may do. (Note: A DNR may be reversed if you so desire.)

Choices

Why would one choose to prepare a DNR? Because, as we've discussed above, there are times when it may not make sense to perform CPR. As an illness progresses, there usually comes a time when continued treatment will no longer reduce symptoms nor heal the person and he/she is in an end stage of the disease. (When a person is becoming more and more sick, doctors may try various treatments to stop the illness, but eventually it may become clear that treatments are not having the desired effect. Other treatments might provide comfort, and might even partly control the disease, but a point may be reached where nothing will stop the person's decline.) Under these circumstances, you might feel there is little reason to attempt CPR, as it (at this point, CPR) may only prolong dying. This allows natural death to occur. In fact, the original name of the DNR form was "DNAR" for "Do Not Attempt Resuscitation." This name recognized the fact that the form instructed the 911 responders not to undertake something that, despite the best efforts, would not work effectively in the long run. At most, the effort might put the sick person in the hospital, in pain and distress, for the last days of his or her life. Having a DNR prepared may also relieve the caregiver of making a decision to turn off a machine, which can be an even more difficult decision psychologically.

(See the fact sheets *Advanced Illness: Holding On and Letting Go* and *End-of-Life Decision Making* for more discussions about this issue).

Conclusion

When someone is suffering from a chronic illness, as opposed to an acute illness (the kind that usually requires a hospital visit or stay), the decline is often gradual. As a result, both caregivers and those in their care often forget to talk about the choices the chronically ill person would like to make regarding his or her health care. If you decide that you do not want CPR and are concerned about this decision, it might help to talk with your physician and clergyperson. It is normal, instinctive, to try to save life no matter what, and some people are concerned that not doing everything possible to preserve life is the same as "killing" someone. But it can also simply mean respecting the end

stage of a disease as the body shuts down and death naturally occurs.

There are no right and wrong answers to these questions, and until we face a situation like this, it is difficult to anticipate the kinds of choices we'd make. As we change throughout the course of an illness, our choices might also change. However, the more thoroughly family members have discussed these issues in advance of the need to make a critical decision, the easier it will be on both the person who is ill and those responsible for that person's care. It is never too soon to start the conversation. Hospice care can relieve suffering and provide support to patients and families facing these crises.

Credits

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Dementia Care Practice Recommendations, Phase 3: End of Life Care, Alzheimer's Association, http://www.alz.org/national/documents/brochure_dcprphase3.pdf

Resources

Southern Caregiver Resource Center
891 Kuhn Drive, Ste. 200
Chula Vista, CA 91914
(858) 268-4432 | (800) 827-1008 (in CA)
Fax: (858) 268-7816
E-mail: scrc@caregivercenter.org
Web site: www.caregivercenter.org

The Southern Caregiver Resource Center offers services to family caregivers of adults with chronic and disabling health conditions and is for residents of San Diego and Imperial counties. Services include information and referral, counseling, family consultation and case management, legal and financial consultation, respite care, education and training, and support groups.

Family Caregiver Alliance
(415) 434-3388 | (800) 445-8106
Web site: www.caregiver.org
E-mail: info@caregiver.org

Family Caregiver Alliance (FCA) seeks to improve the quality of life for caregivers through education, services, research and advocacy. Through its National Center on Caregiving, FCA offers information on current social, public policy and caregiving issues and provides assistance in the development of public and private programs for caregivers.

Alzheimer's Association
www.alz.org

Compassion & Choices
www.compassionandchoices.org

National Hospice and Palliative Care Organization
www.nhpco.org

Dying Unafraid
Fran Johns

Five Wishes
www.agingwithdignity.org/five-wishes

Five Wishes is a document that helps you express how you want to be treated in the event you become seriously ill and unable to speak for yourself.

Handbook for Mortals
Joanne Lynn, MD and Joan Harrold, MD
Americans for Better Care of the Dying
www.abcd-caring.org

Making Sacred Choices at the End of Life
Rabbi Richard Address,
Jewish Lights Publishing, 2000.
http://www.jewishlights.com/page/product/JL9

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