

## JOINT STATEMENT ON RESUSCITATIVE INTERVENTIONS

(UPDATE 1995)

# Making Decisions About CPR

CARDIOPULMONARY  
RESUSCITATION

## JOINT STATEMENT

1995

Produced by

Canadian  
Healthcare  
Association

Canadian Medical  
Association

Canadian Nurses  
Association

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This joint statement includes: guiding principles for health care facilities when developing cardiopulmonary-resuscitation (CPR) policy; CPR as a treatment option; competence; the treatment decision, its communication, implementation and review; and palliative care and other treatment. This joint statement was approved by the Canadian Healthcare Association, the CMA, the Canadian Nurses Association and the Catholic Health Association of Canada and was developed in cooperation with the Canadian Bar Association.

This joint statement is intended to provide guidance for the development of policies regarding the appropriate use of cardiopulmonary resuscitation (CPR). It replaces the 1984 Joint Statement on Terminal Illness and applies to all recipients, including children. The sponsors of this statement encourage healthcare facilities to develop policies for their institutions.

CPR was developed as a treatment intervention for cases of sudden unexpected cardiac or respiratory arrest. CPR is understood to include mouth-to-mouth resuscitation, chest compression, bag-and-mask positive-pressure ventilation, intubation and defibrillation. However, unless a specific order to the contrary (do-not-resuscitate [DNRD] has been recorded on the person's health record by the responsible physician, it has come to be used as a standard intervention in virtually all cases of sudden cardiac or respiratory arrest, whether unexpected or not. [Throughout this document "arrest- is taken to include severe bradycardia in children.]

After several decades of experience and review, it appears that there are people who benefit from this treatment and others for whom there is no benefit and potential significant harm. In these latter situations, CPR is not only generally unsuccessful but also inappropriate, as it may serve only to increase pain and suffering and prolong dying. Withholding resuscitation does not imply the withholding of treatment and supportive care, including palliative care.

It is timely to reconsider the use of resuscitative interventions in the context of a changing societal environment, which recognizes the autonomy of the individual, encourages increased public discussion of bioethical issues and stresses the need for empirical evidence of positive patient outcomes following treatment.

## **POLICY DEVELOPMENT**

### **General**

Health care facilities are encouraged to make use of an interdisciplinary committee to develop a policy, a program for policy implementation and a conflict-resolution mechanism. This committee should include lay people and representatives of medicine, nursing, social work, pastoral care and other disciplines as required, with access to legal and ethical consultation.

The policy should identify which resuscitative interventions are available in the facility; with the conflict-resolution mechanism, it should ensure sensitivity to cultural and religious differences. The implementation program should include education of all those who will be affected by the policy, including caregivers. The policy must be in accordance with relevant federal and provincial or territorial law. It should be reviewed regularly and revised when necessary in light of developments in clinical, ethical and legal aspects of the topic.

Since policies and guidelines cannot cover all possible situations, appropriate consultation mechanisms should be available to address specific issues in a timely manner .

### **Guiding principles**

The following principles are integral to the development of CPR policy:

1. Good health care requires open communication, discussion and sensitivity to cultural and religious differences among caregivers, potential recipients of care, their family members and significant others.
2. A person must be given sufficient information about the benefits, risks and likely outcomes of all treatment options to enable him or her to make informed decisions.
3. A competent person has the right to refuse, or withdraw consent to, any clinically indicated treatment, including life-saving or life-sustaining treatment. Competence can be difficult to assess because it is not always a constant state. A person may be competent to make decisions regarding some aspects of life but not others; as well, competence can be intermittent -a person may be lucid and oriented at certain times of the day and not at others. The legal definition and assessment of competence are governed by the provinces or territories. Facilities should be aware of the laws (e.g., capacity to consent and age of consent) regarding the assessment and documentation of incompetence.
4. When a person is incompetent, treatment decisions must be based on his or her wishes, if these are known. The person's decision may be found in an advance directive or may have been communicated to the physician, other members of the health care team or other relevant people. In some jurisdictions, legislation specifically addresses the issue of

decision making concerning medical treatment for incompetent people; the legislative requirements should be followed.

5. When an incompetent person's wishes are not known, treatment decisions must be based on the person's best interests, taking into account:
  - (a) the person's known values and preferences,
  - (b) information received from those who are significant in the person's life and who could help in determining his or her best interests,
  - (c) aspects of the person's culture and religion that would influence a treatment decision, and
  - (d) the person's diagnosis and prognosis.

In some jurisdictions legislation specifies who should be recognized as designated decision-makers (proxies) for incompetent people; this legislation should be followed. The term "proxy" is used broadly to identify those people who make a treatment decision based on the decision a person would have made for himself or herself (substitute decision-maker), people who help in determining what decision would be in the person's best interest and people whose appropriateness to make treatment decisions for the person is recognized under provincial legislation.

6. There is no obligation to offer a person futile or nonbeneficial treatment. Futile and nonbeneficial treatments are controversial concepts when applied to CPR. policymakers should determine how these concepts should be interpreted in the policy on resuscitation, in light of the facility's mission, the values of the community it serves, and ethical and legal developments. For the purposes of this document and in the context of resuscitation, "futile" and "nonbeneficial" are understood as follows. In some situations a physician can

determine that a treatment is "medically" futile or nonbeneficial because it offers no reasonable hope of recovery or improvement or because the person is permanently unable to experience any benefit. In other cases the utility and benefit of a treatment can only be determined with reference to the person's subjective judgement about his or her overall well-being. As a general rule a person should be involved in determining futility in his or her case. In exceptional circumstances such discussions may not be in the person's best interests. If the person is incompetent the principles for decision making for incompetent people should be applied.

### **CPR as a treatment option**

The efficacy of CPR in restoring cardiac and respiratory functioning varies from nil to very high, depending on a number of factors. On the basis of research studies of such outcomes four general categories can be distinguished.

1. People who are likely to benefit from CPR.
2. People for whom benefit is uncertain.
3. People for whom benefit is unlikely.
4. People who almost certainly will not benefit.

These categories can be adapted to the particular circumstances of the care setting and are compatible with policies that establish levels of care or intervention.

### **Competence**

Determination of competence is made by the attending physician in consultation with other caregivers. If the person for whom resuscitation is being considered is incompetent, decisions should be made on his or her behalf as indicated earlier (guiding principles 4 and 5). If the person's incompetence is uncertain or intermittent, efforts should be made to facilitate the regaining of competence.

## Treatment decisions

Treatment decisions about potential resuscitative interventions should be made within the context of discussions concerning the plan of treatment and on the basis of the person's medical condition and his or her expressed wishes. These decisions should be considered before the need for intervention arises or a crisis occurs. They should be made in the context of the person's autonomy and with full disclosure of options in a supportive environment.

1. People who are likely to benefit from CPR: There is a good chance that CPR will restore cardiac and respiratory function and that the restored function will be maintained. The likelihood of the person's returning to his or her pre-arrest condition is high.
2. People for whom benefit is uncertain: The person's condition or prognosis or both may not have been assessed before the loss of cardiac and respiratory function. It is unknown or uncertain whether CPR will restore functioning. The subsequent prognosis or the likelihood of adverse consequences is also unknown or uncertain.
3. People for whom benefit is unlikely: There is little chance that CPR will restore cardiac and respiratory function; even if the function is restored, it is unlikely to be maintained. The likelihood of the patient's returning to his or her pre-arrest condition is low.
4. People who almost certainly will not benefit: There is almost certainly no chance that the person will benefit from CPR, either because the underlying illness or disease makes recovery from arrest virtually unprecedented or because the person will be permanently unable to experience any benefit.

## Communication

1. Health care recipients  
Informed consent to any treatment implies that

the individual has a clear understanding of the treatment options and the possible outcomes. Information must be provided in a language that the person can understand. The implications of the person's choices should be explored in the context of life goals, values and preferences.

Communication about CPR should take into account the clinical condition of the person:

- (a) People who are likely to benefit from CPR and people for whom benefit is uncertain will normally be made aware that emergency, life-saving measures will be instituted if the need arises. This information should be presented during discussion about the plan of treatment so as not to alarm the person.
- (b) People for whom benefit from CPR is unlikely should be made fully aware of the limitations of CPR. Their life goals, values and preferences should be discussed before or shortly after admission to a health care facility, before the need for resuscitative intervention arises.
- (c) People who almost certainly will not benefit from CPR are not candidates for CPR, and it should not be presented as a treatment option. Whether this is discussed with the person is a matter of judgement based on the circumstances of the case and the principles specified earlier.

2. Family members and significant others  
Members of the health care team should encourage a person to advise family members, significant others and potential proxy decision-makers of his or her decision about CPR. Such communication should be documented on the person's health record.

3. Health care providers  
Decisions about whether CPR is an appropriate treatment option should be clearly noted on the person's health record along with the outcome

of any discussions so that all health care providers involved in his or her care are aware of these decisions. Communication and discussion among those involved in providing care to the person are vital in ensuring that the individual's decisions are respected.

Because nurses, social workers and pastoral care workers have a unique opportunity to explore end-of-life issues in detail, they should be kept fully informed about the treatment plan of each person under their care, including decisions regarding CPR.

### **Implementation of decisions**

1. Situations in which CPR should be performed. People likely to benefit from CPR should be given this treatment if the need arises, unless they have specifically rejected it. People for whom the benefit of CPR is uncertain or unlikely should be given this treatment if the need arises, unless they have specifically rejected it. CPR should be initiated until the person's condition has been assessed.

2. Situations in which CPR should not be performed. People who have rejected CPR and those who almost certainly will not benefit from it should not be given this treatment if an arrest occurs.

### **Review of decisions**

Appropriate intervals for review of decisions concerning CPR should be determined. The review should follow the same guidelines as the original decision regarding resuscitation. In the following circumstances a review of decisions should be undertaken immediately:

1. If a competent person (or proxy) changes his or her decision about resuscitation.
2. If there is a significant, unexpected change in a person's condition.

## **PALLIATIVE CARE AND OTHER TREATMENTS**

A decision not to initiate CPR does not imply the withholding or withdrawing of any other treatment or intervention.

A person who will not receive CPR should receive all other appropriate treatments, including palliative care, for his or her physical, mental and spiritual comfort.