The views of elderly patients and their relatives on cardiopulmonary resuscitation

ABSTRACT—Little was previously known of the factors that may influence patients and relatives when asked to make decisions on cardiopulmonary resuscitation. Attitudes towards resuscitation in general appear to influence the wishes of elderly patients and their relatives for cardiopulmonary resuscitation. Knowledge of the procedure involved in cardiopulmonary resuscitation and its success rate and the patients’ sex and health status do not influence their wishes.

Recent guidelines for ‘do not resuscitate’ orders are ambivalent about the role of patients and their relatives in this clinical decision [1]. While medical decisions are influenced by knowledge of outcome and by the guidelines drawn up by professional bodies, little is known of what may influence the views of patients and relatives. What does influence them? To what extent do patients’ own views correspond with those of their relatives and of the doctors responsible for their hospital care?

Methods

A consecutive series of patients due to be discharged from the acute geriatric wards of a district hospital were interviewed over four months. Of the 187 patients due to be discharged, 24 were excluded from the study because of dementia, five because of communication problems, and six refused to be interviewed. In the final sample, there were 39 men and 61 women, and their mean age was 82 years (range 70 to 97 years). The patients’ main diagnosis, their resuscitation status, living circumstances at discharge, mobility and level of functioning (Barthel index) [2] were recorded. Patients and relatives were given a semi-structured interview (available from authors) to examine their understanding of and attitudes towards cardiopulmonary resuscitation.

Results

Seventy-one relatives were interviewed, three refused, and five could not be contacted. Six patients had no suitable next-of-kin, and 15 patients refused permission for their next-of-kin to be contacted. After a general introduction to the study, patients were asked whether they knew what procedures were involved when a patient had a cardiac arrest in hospital. Just under one-third (30%) mentioned the following key points: cardiac massage, care of the airway, and giving oxygen. Fifty-three per cent did not know what was involved, while 17% indicated incomplete or inaccurate knowledge. When they were asked about the success of the procedure in elderly patients, 56% believed it was successful in most cases.

Patients were then asked if they would have wished to be resuscitated had their heart stopped beating at some point in their hospital stay. While 78% expressed a wish to be resuscitated, only 28% would have liked to be involved in the decision at admission; 43% believed the doctor alone should take the responsibility; 34% thought the responsibility should be shared between doctor, patients, and/or their relatives; while 23% considered that the responsibility should lie with patients and/or their families alone. When asked why they would prefer to be resuscitated, 84% stated that they enjoyed life and wanted to live; while only 5% made reference to their expected quality of life, 5% mentioned expectations about further treatment, and 1% gave religious reasons. The majority of those who did not wish to be resuscitated (16 out of 22: 73%) gave as their reason either advanced age or expectations of a poor quality of life. Only one patient mentioned low success rates as a factor in this decision.

Patients were next asked for their views about the desirability of resuscitating the following groups of patients: all people aged over 65 regardless of their health status (33% said yes); elderly patients with terminal cancer (18% said yes); elderly patients with dementia (24% said yes); elderly patients physically very disabled (48% said yes); and any patient who is aged over 65 (93% said yes). Finally, patients were asked about their attitude to euthanasia, and 60% favoured it.

The relatives were asked similar questions. Sixty-five per cent had an understanding of resuscitation, 37%...
believed it was successful, 70% would have wanted their dependant to be resuscitated, and 45% would have liked to be involved in the decision. Seven per cent of relatives were prepared to take sole responsibility for the decision, 47% thought the doctor should, 4% considered it should be the sole responsibility of the patient and/or the family, and 42% said it should be the joint responsibility of doctors, patients, and family. Relatives’ views of resuscitating different groups of patients were similar to those expressed by patients: 94% thought people aged over 65 should be resuscitated; 47% thought elderly people with serious physical disability should be resuscitated; 20% if they were demented; 15% if they had terminal cancer; and 16% that all elderly people regardless of their health status should be resuscitated. Seventy-seven per cent of relatives favoured euthanasia.

We next examined the relationship between patients’ expressed preferences for resuscitation and such factors as their functional status (Barthel index and level of mobility), diagnosis including presence or absence of cardiovascular disease, age, gender, whether or not living alone, level of home-care support, knowledge of cardiopulmonary resuscitation procedure, beliefs about its success, whether or not patients wished to be involved in such decisions on admission, and who they thought should take lead responsibility for such decisions. None of these variables was significantly associated with resuscitation preference, nor was any of them related to the relatives’ preferences, with the exception that both young and old relatives were more often in favour of resuscitation than those in middle age (chi-square = 9.7, df 3, \( p < .05 \)). In most cases, both patients and relatives agreed about their wishes for resuscitation (74% of patient/relative pairs showed agreement: chi-square = 7.5, df 1, \( p < .01 \)).

The following factors were associated with the patients’ wish for resuscitation: not being in favour of euthanasia, and support for resuscitating elderly people in general, people with physical disability, people with dementia, people with terminal cancer, and all elderly people. There was a similar trend for the relatives’ wish for resuscitation to be associated with these same factors, but this only reached significance in their support for resuscitating people with severe physical disability. Only 11 patients were down for resuscitation and in all cases both the patients and relatives wished for resuscitation to be applied.

Discussion

Our findings indicate that 78% of patients awaiting discharge from geriatric wards expressed a wish for resuscitation, which contrasts with the only previous UK study where less than half (43%) wished to be resuscitated [3]. In that study there was a significant difference between men and women, but our results suggest that neither sex, patients’ health status, nor knowledge about the procedure influence patients’ and relatives’ views on cardiopulmonary resuscitation. Only one patient in the whole study mentioned the likely success rate for the procedure as a reason for not wishing to be resuscitated, and for most patients their wish to live was the most important reason given for wanting to be resuscitated. On the other hand the attitudes and values expressed towards resuscitation and the preservation of life in general do influence both patients’ and relatives’ wishes. This is in contrast with the judgments of doctors and nurses, which are based upon clinical considerations and knowledge of likely outcome and success. Such contrasting bases for this decision illustrate the difficulties of establishing consensus between doctors, patients, and their relatives. The fact that patients desire cardiopulmonary resuscitation much more than their doctors consider appropriate suggests the need for more discussion between doctors and their patients. The overestimation of the success rate of cardiopulmonary resuscitation by patients suggests a need to educate the general public on the limited success of this procedure, although such education may not necessarily change the views and wishes of patients [4].

References

1. Williams R. The ‘do not resuscitate’ decision: guidelines for policy in the adult. J R Coll Physicians Lond 1993;27:399–40.
2. Mahoney FI, Barthel DW. Functional evaluation: the Barthel index. Maryland State Med J 1965;14:61–5.
3. Gunasekera NPR, Tiller DJ, Clements LTSJ, Bhattacharya BK. Elderly patients’ views on cardiopulmonary resuscitation. Age Ageing 1986;15:364–8.
4. Schonwetter RS, Teasdale TA, Taffet G, Robinson BE, Luchi RJ. Educating the elderly: cardiopulmonary resuscitation decisions before and after intervention. J Am Geriatr Soc 1991;39(4):372–7.

Address for correspondence: Dr Jane Liddle, Frimley Park Hospital, Portsmouth Road, Frimley, Surrey GU16 5UJ.