Effect communication with patients and their carers is the most important issue surrounding cardiopulmonary resuscitation (CPR). The need to develop sensitive and reliable ways to improve communication and help patients make valid choices cannot be overemphasised.

For the majority of hospitalised patients CPR is an unlikely event, and hence provision of detailed information to every patient particularly when not requested would be inappropriate and could be misinterpreted. The emphasis should be on giving patients the opportunity to be involved in end of life decisions rather than to compel them to become involved or make choices.

There is evidence that few patients actually want to be involved in final resuscitation decision making. There is also evidence that a significant proportion of medical professionals have concerns regarding initiating discussion relating to resuscitation issues. High demand on doctor and nurse time makes it even more difficult for patients to acquire detailed information and make informed choices.

We explored two methods of communicating sensitive information on CPR to hospitalised patients and their carers.

Our aim was to offer information in a humane manner to those who were interested but to avoid imposing on patients who were not keen to know.

DESIGN AND METHODS

The study was approved by the Trust’s Resuscitation Committee and the Board of Clinical Practice. Comments were also invited from the Trust’s ethics committee.

The study was conducted over a three month period from June to September 2002. All patients admitted to a designated general medical ward and an acute elderly care ward were included.

The detailed information leaflet (appendix I; please visit www.jmedethics.com/supplemental) contained literature on most aspects of CPR which could be of use to the patients or their carers, and was kept by the nursing staff on both wards with a view to providing it to patients or their carers on request. Records were kept regarding handling out this information and written feedback was requested in the form of a questionnaire survey. The completed questionnaire was sent to the audit department.

The summary document (appendix II; please visit www.jmedethics.com/supplemental) was produced in large print and was laminated and provided basic information on CPR. It encouraged the reader to seek more information if they desired and to acquire the detailed information leaflet, which was also available in larger print for people with impaired vision.

On the elderly care ward the summary document was placed at the foot of each bed. This was the first document within a folder. It was available to patients and their carers if they wished to read it. On the medical ward the summary document was pasted in a prominent position over the head of each bed.

Training was organised for the nursing staff on both wards before the study. Records were kept for any concerns or complaints expressed by the patients, their relatives, or indeed any member of the staff.

RESULTS

During the three months 456 patients were admitted to the two wards. Out of the 274 patients admitted to the general medical ward only two requests were received for the information leaflet. Those who sought this information found it to be very useful. No requests for information leaflets were received from the relatives.

On the elderly care ward there were 182 admissions but no patients or their relatives requested the leaflet.

Abbreviation: CPR, cardiopulmonary resuscitation.
DISCUSSION
There is a general consensus on identifying patients not suitable for CPR, thus ensuring dignity at the end of life. However, controversy surrounds discussions on CPR with every intellectually competent patient. There are some who favour frank discussion with every patient respecting the patient’s autonomy while others do not approve of such discussions if the “not to resuscitate” decision is made on the grounds of futility. The advocates of the latter point out that failing to take into account the emotional impact of such a discussion could be devastating for a frail and ill patient. This could even be construed as being inhumane at a time of maximal emotional vulnerability. The psychological pain caused by such discussions with patients and the resulting uneasiness among medical professionals is well recognised.

Another fundamental question is whether all patients are interested in the CPR decision making process. The literature shows wide variation in reported percentage of interested patients. Some studies have interviewed patients who were about to be discharged from hospitals. Others used outpatient settings and therefore were not truly representative of hospitalised patients with significant pathology in whom CPR is a likely outcome.

The joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing suggested that written information about resuscitation policies should be included in the general literature provided to patients in hospitals and patients should be encouraged to see such information. As cardiorespiratory arrest is a rare event for the majority of hospitalised patients, provision of detailed information to each patient would neither be practical nor appropriate.

Rather than providing detailed information to every patient, we explored the use of a summary document (appendix II) and found it to be a practical way of communicating basic CPR information. This method did not generate anxiety or complaints and helped in making the decision making process more transparent for patients and their carers. During the study period, no formal requests were made by patients or their relatives for discussions with medical teams.

The detailed information leaflet was available only for those who wished to acquire such information. The patients who desired this material were expecting explicit information on end of life issues and therefore were neither disturbed nor offended by it. Although rated to be useful by those who requested these leaflets, their uptake was low.

We also explored two different methods of offering basic CPR information to patients on the wards. The medical ward had the summary document pasted above the head of each bed. Despite the document being in a prominent position, in our experience this did not subject the patients or their relatives to unnecessary anxiety.

Our study had a few inherent weaknesses. Although efforts were made to place the summary document in a prominent position on each ward, it was not recorded whether every patient or their carer had the opportunity to examine this information. However, any attempt to do so may have inadvertently compelled some patients to discuss CPR issues against their wishes. The other weakness of this study was the inability to identify the proportion of patients who were incompetent and/or were unable to read. The results showed that the overwhelming majority of the patients or their relatives did not initiate discussion about CPR, a trend seen in published literature. However, the design of this study cannot determine the precise reason for this trend. Further research is needed to elucidate the reasons for low uptake of detailed information on CPR. Feedback on information leaflets from patients, their carers, and relatives would be desirable in improving communication on end of life issues.

CONCLUSIONS
We conclude that availability of basic information on cardiopulmonary resuscitation to all patients is practical and does not lead to unnecessary distress or offence to patients or their carers. It makes the decision making process more transparent and helps improve the patient’s confidence. Detailed information leaflets are of value for a minority of hospitalised patients.

The appendices can be viewed on the JME website (www.jmedethics.com/supplemental).

Authors’ affiliations
R Sivakumar, P Ghosh, S Khan, Department of Elderly Care, Lister Hospital, Stevenage, UK
J Knight, C Devlin, East and North Hertfordshire NHS Trust, UK
P Keir, Department of Cardiology, Queen Elizabeth II Hospital, Welwyn Garden City, UK
Correspondence to: Dr R Sivakumar, Stratthmore Wing, Lister Hospital, Coresys Mill Lane, Stevenage, UK; sivasiva51@hotmail.com

REFERENCES
Cardiopulmonary resuscitation is not an easy subject to talk about, but it is important that you should know all that you can so that you can make an informed decision about the treatment you would or would not like to receive should you have a cardiac arrest. This leaflet aims to provide you with information that will help you to come to a decision about whether you would wish to be resuscitated or not. It is not a substitute for a discussion with those involved in your care but will serve as another source of information for you about resuscitation.

What is Cardiopulmonary Resuscitation?
"Cardiopulmonary Resuscitation", “CPR” and “resuscitation” all mean the same. They are terms for the emergency treatment used to try to restart a person’s heart and breathing if these stop. This is called a “cardiopulmonary arrest” or more commonly known as a “cardiac arrest”. A cardiac arrest is a sudden event, which is not easy to predict. It can happen to anyone at any time. However some people may be at higher risk of suffering a cardiac arrest than others.

Is a Cardiac Arrest the same as a heart attack?
No, a Cardiac Arrest is different to a heart attack. A heart attack causes severe pain in the centre of the chest. The pain may last for several hours. It usually feels like a heaviness or tightness, which may spread to the arms, neck, jaw, back or stomach. There may also be sweating, faintness, nausea or shortness of breathe. A heart attack may cause the rhythm of the heart to be disturbed and thus cause a cardiac arrest.

What can be done if I have a Cardiac Arrest?
If you suffer a cardiac arrest you will need the following for any chance of survival: mouth-to-mouth resuscitation or artificial respiration (in hospital we use a mask to do this).
vigorous massage of the chest to move the blood around the body—known as chest compressions or cardiac massage.
electric shocks to the chest to start the heart.
injections into the veins to help the blood flow.
a tube into the windpipe to help breathing.

What happens if I stop breathing only?
When you stop breathing but your heart continues to beat you are said to have suffered a “respiratory arrest”. This can happen for a number of reasons such as advanced lung disease, injury to the brain and reaction to certain drugs etc. A respiratory arrest can be life threatening. The heart may stop if treatment is not started immediately.
If you suffer a respiratory arrest you will need mouth-to-mouth resuscitation or artificial respiration (in hospital we use a mask to do this).
Where will I be resuscitated?
For the best possible chance of a successful outcome it is important for CPR to be started as quickly as possible. Anyone trained in CPR can attempt CPR and therefore it can be carried out by the general public, staff in nursing homes, special schools, doctors and dental surgeries etc. In hospital there are expert teams who can provide CPR using specialised equipment which will be brought to you.

Is resuscitation always successful?
Resuscitation is not always successful. Unfortunately television programmes often give the impression of very high success rates. The truth is that success varies widely. Success depends on a number of factors, some of which are: the speed at which treatment is started after the person collapses and the condition of the person before collapse. The chance of CPR being successful will depend on:
Why your heart has stopped
Any illnesses you have
Your overall health
Time before CPR is commenced
Age cannot indicate the likelihood of success. A fit eighty year old may survive and an unfit forty year old may die.

Do people get back to normal after CPR?
Some people make a full recovery, but unfortunately CPR does not always start the heart and lungs. In some cases the person may suffer complications. The type and severity of the complications vary depending on a wide range of factors. Severe complications include brain injury and less serious ones may be broken ribs or minor skin burns. Patients who are successfully resuscitated usually need to be cared for in a high dependency unit for a while afterwards.

Is everyone resuscitated?
In an emergency, for example if the heart and lungs stop working unexpectedly or you suffer a traumatic accident or heart attack, the priority will be to save your life. Your age alone does not affect the decision to resuscitate, nor does the fact that you may have a disability. Unfortunately resuscitation is not a treatment that will bring a successful outcome for every person and therefore is not done for everyone. Each case must be assessed individually. If you wish to discuss the likelihood of success with your medical team please ask your nurse to arrange a time for you to speak to them. You may wish to have a relative, partner or close friend with you for this discussion. Also some people with advanced disease would prefer not to have resuscitation attempted. Do not be alarmed if your doctor speaks to you about resuscitation. It is better to have reached a decision in advance.

What if I am unable to make a decision at the time?
If for example you are brought into an A&E department unconscious, the normal policy is to resuscitate you. But if you became unconscious because you have terminal disease such as cancer, other severe disease or an injury so severe that survival is unlikely, the
medical staff when in possession of the full facts may make a decision for you. This decision may be not to attempt CPR.

**Can anyone else make this decision for me?**
No, in England, Wales and Northern Ireland if you are over 18, your family and friends cannot decide for you. You can appoint someone to represent you should you become unable to speak for yourself. Your wishes can be relayed via this person. However it may be a good idea to write your wishes down before this time and tell someone where this can be found. You should also tell the medical team, which may include your GP, Consultant, Nurse etc. This is often called a Living Will or Advanced Directive or Statement.

**What if I say I do not want resuscitation to be attempted?**
Rest assured that you would be given the best of care as normal. Just because you have decided not to be resuscitated in the event of a cardiac arrest, does not mean that you cannot have other medical treatment and of course full nursing care.

**What if I change my mind?**
You can change your mind at any time, and talk to the Doctors and Nurses caring for you. The health care team looking after you will regularly review decisions about CPR, particularly if your condition changes and if your wishes change.

**What if I want resuscitation to be attempted, but my doctor doesn’t agree?**
It is always difficult to come to terms with the possibility of dying and no doctor would refuse your wish for CPR if there was any real possibility of it working successfully and returning you to health. In most cases doctors and their patients agree about treatment where there has been good communication. However the health care team will arrange for a second medical opinion for you if you would like one.

**Where will the decision not to attempt resuscitation be documented?**
The decision will be written in your medical and nursing records. This decision will be reviewed regularly and your records changed as necessary.

Where to get more information
You may wish to talk to:
- One of the Doctors in the team caring for you
- A member of the Nursing Staff
- Your GP
- Specialist Nurse
- Family/partner
- Close friend/carer
- Spiritual Leader
- Counsellor

The Resuscitation Council (UK) provides guidance for Medical Staff and Nursing Staff on resuscitation policies and procedures. East and North Hertfordshire NHS Trust has an agreed policy and guidance for staff on decisions about who not to resuscitate (April 2001).
Appendix II

**Patient information regarding cardiopulmonary resuscitation**
Cardiopulmonary resuscitation (CPR) is not an easy subject to talk about, but it is important that you should know all that you can so that you can make an informed decision about the treatment you would or would not like to receive should your heart and breathing suddenly stop. The term for this is cardiac arrest. The staff can give you a short booklet to read that will provide information that will help you to come to a decision about whether you would wish to be resuscitated or not. It is not a substitute for a discussion with those involved in your care but will serve as another source of information for you about resuscitation. If you wish to speak to your Doctor about Resuscitation please ask the staff to arrange this.

If you wish to read a copy of the booklet please ask the staff for a copy. The booklet is available in the following format:

- Large Print