
Palliative Care Resuscitation

MADLINE BASS

Palliative Care Nurse Specialist

RGN, MIFA, BSc (Hons)



John Wiley & Sons, Ltd

Palliative Care Resuscitation

Palliative Care Resuscitation

MADLINE BASS

Palliative Care Nurse Specialist

RGN, MIFA, BSc (Hons)



John Wiley & Sons, Ltd

Copyright © 2006 John Wiley & Sons Ltd
The Atrium, Southern Gate, Chichester,
West Sussex PO19 8SQ, England
Telephone (+44) 1243 779777

Email (for orders and customer service enquiries): cs-books@wiley.co.uk

Visit our Home Page on www.wiley.com

All Rights Reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, scanning or otherwise, except under the terms of the Copyright, Designs and Patents Act 1988 or under the terms of a licence issued by the Copyright Licensing Agency Ltd, 90 Tottenham Court Road, London W1T 4LP, UK, without the permission in writing of the Publisher. Requests to the Publisher should be addressed to the Permissions Department, John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex PO19 8SQ, England, or emailed to permreq@wiley.co.uk, or faxed to (+44) 1243 770620.

Designations used by companies to distinguish their products are often claimed as trademarks. All brand names and product names used in this book are trade names, service marks, trademarks or registered trademarks of their respective owners. The Publisher is not associated with any product or vendor mentioned in this book.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold on the understanding that the Publisher is not engaged in rendering professional services. If professional advice or other expert assistance is required, the services of a competent professional should be sought.

Other Wiley Editorial Offices

John Wiley & Sons Inc., 111 River Street, Hoboken, NJ 07030, USA

Jossey-Bass, 989 Market Street, San Francisco, CA 94103-1741, USA

Wiley-VCH Verlag GmbH, Boschstr. 12, D-69469 Weinheim, Germany

John Wiley & Sons Australia Ltd, 42 McDougall Street, Milton, Queensland 4064, Australia

John Wiley & Sons (Asia) Pte Ltd, 2 Clementi Loop #02-01, Jin Xing Distripark, Singapore 129809

John Wiley & Sons Canada Ltd, 6045 Freemont Blvd, Mississauga, Ontario, L5R 4J3, Canada

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Library of Congress Cataloging-in-Publication Data

Bass, Madeline.

Palliative care resuscitation / Madeline Bass.

p. ; cm.

Includes bibliographical references and index.

ISBN-13: 978-0-470-01977-1 (pbk. : alk. paper)

ISBN-10: 0-470-01977-8 (pbk. : alk. paper)

1. Palliative treatment.
2. Terminal care.
3. Resuscitation. I. Title.
- [DNLM: 1. Cardiopulmonary Resuscitation. 2. Advance Directives.
3. Guideline Adherence. 4. Nurse's Role. 5. Palliative Care – methods.
6. Resuscitation Orders – ethics. WG 205 B317p 2006]

R726.8.B37 2006

616'.029 – dc22

2006008577

A catalogue record for this book is available from the British Library

ISBN-13 978-0-470-01977-1

ISBN-10 0-470-01977-8

Typeset in 10/12pt Times by SNP Best-set Typesetter Ltd., Hong Kong

Printed and bound in Great Britain by TJ International Ltd, Padstow, Cornwall

This book is printed on acid-free paper responsibly manufactured from sustainable forestry in which at least two trees are planted for each one used for paper production.

Contents

Preface vii

Acknowledgements viii

1 The history of cardiopulmonary resuscitation 1

2 CPR versus active treatment in palliative care 6

3 Resuscitation guidelines, success and futility, and medical paternalism 28

4 Cultural and religious influences, including the ‘sick role’, on healthcare and resuscitation decisions 46

5 The role of the nurse and the nurse–doctor–patient relationship in resuscitation decisions 58

6 Making resuscitation decisions: involving patients and their family carers 73

7 Hope in patients who are palliative and have had a DNAR order made 95

8 The law and ethics surrounding resuscitation 100

9 Resuscitation in the community 121

10 The future of resuscitation 129

Conclusion 131

Further reading 132

References and bibliography 136

Index 148

This book is dedicated to my husband, Andrew, without whose support I would not have achieved anything in life, and would not have finished this book. Thanks for all the shopping, cleaning and ironing you have done to enable me to have time to do this.

Preface

I feel very privileged to have been given the chance to write this book, something I have always wanted to do but never thought I would.

The subject of resuscitation in palliative care has been one close to my heart for a few years now, since carrying out some research for my dissertation. The research was based on oncology nurses' perceptions of resuscitation status for oncology patients. Although only a small study it generated some interesting points and clarified certain issues. From this I became involved in our Trust's patient information group for producing patient and family carer's information on resuscitation. From this, I have been able to undertake teaching sessions on the subject, not only within my own Trust but also to others.

The study and learning that writing this book has generated for me has given me even greater knowledge and insight into the subject of resuscitation in palliative care and I hope this book, written mainly for nurses and other allied health professionals, will fire up others to take this forward within their own Trusts and areas of patient care. The subject is by no means a cut and dried one; indeed, there are many grey areas. But I hope this book will aim to resolve some of the questions and ethical considerations the topic generates and encourage all healthcare workers that it is an area of major importance.

Certain phrases have been used throughout the book which may not be familiar to the reader. For instance, the phrase 'Do Not Attempt Resuscitation' (DNAR) has been used for people who are given an order not to receive cardiopulmonary resuscitation. This is the phrase recommended to be used by the resuscitation guidelines, for those patients who should not receive it. The term 'family carers' has been used for anyone who is a friend, relative or next of kin to the patient. This is now the correct term for any significant other who is involved in caring for the patient. And, yes, I have used the term patient, and not client, within the book, for this reason: I do not feel any person who develops a palliative illness is a client, since the word *client* generates visions, to me, of someone who has entered into a contract with someone else through choice. I am sure most, if not all, palliative care patients would not choose to be in the health status they are, hence the use of the word *patient*.

I have chosen some case studies to attempt to highlight certain issues discussed in the chapters. These case studies are entirely fictitious and have only been used as a teaching resource.

Finally, I hope you will enjoy the book as much as I have enjoyed the learning experience and the writing of it. I hope it will enable you to see the value of life and of a good death, and how important palliative care and its principles are. I wish you all a long and happy career in patient care.

Madeline Bass
2006

Acknowledgements

Where to start, I don't know! So many people have been involved in supporting me through this writing process, so for anyone I leave out please forgive me and please realise I am very grateful to you. First, to my long-suffering work colleagues, who have encouraged and supported me, made me many cups of tea when I have been discouraged about the book, and have told me lots of jokes to keep me going. Thanks for being such a great bunch, Nicky, Phil, Hilary, Sally and Libby. I hope we will work together for many years to come. Thanks also to Alison and Lisa, my managers, who have taken an interest in this as well. Thanks to the hospital library staff for all their help over the past year. Thanks to my parents and parents-in-law, who have always asked me how things are progressing and have listened to my whining and complaints when things have not been too easy. Thanks to my friends, Lisa, Liz and Martin, Sarah and Phil, Dave and Kirstie, Helen and Stuart, Kerry and Sue, who have been so fantastic and treated me like a major author. I know they are champing at the bit to read the end result! Thanks to my dog, Mac, for making me take him out for walks when I have been fed up, and for always being a loyal companion. The biggest thanks go to my husband, Andrew, who has been a full-time house-husband as well as full-time worker, and has given me plenty of hugs and cups of tea to help me through. Thank you for all your love, care and humour, which has got me through. I am so proud to be your wife, friend and soulmate.

1 The history of cardiopulmonary resuscitation

The development of modern cardiopulmonary resuscitation (CPR) has influenced today's Western society into feeling that there is control over death at any time. Western society and Western medicine zealously pursues immortality, and because medical research has discovered cures for diseases which decades ago would have killed many, patients have literally been brought back from the brink of death with the new medical technological advances that have been made, such as genetically engineered drugs, organ transplantation and life-support machines and devices. Yet death remains an everyday occurrence.

This feeling of control over death has been reinforced by the media, which has portrayed CPR as dignified, easy to do, appropriate for all and usually successful (BMA *et al.*, 2001). The media, including Hollywood, also portrays death itself as violent, sudden or romantic (Cooley, 2000). The many medical and nursing dramas on television often include incidences of CPR and its portrayal is mostly far removed from reality. Western society is fascinated by death, disease and illness, something which the media has profited from, and this fascination includes CPR. Unfortunately, with CPR, as with many other medical procedures, there is a stark difference between what is portrayed by the media and reality. This leaves the public with little true understanding of what CPR really involves, and often leaves people puzzled, bewildered and angry when it is not appropriate for themselves or their relative.

However, modern CPR (i.e. closed chest cardiac massage, defibrillation and mouth-to-mouth resuscitation) has only been used since 1960. It is amazing how something so relatively new is widely accepted in hospitals and the community alike, is seen as normal and as something to be expected. CPR is the one procedure in medicine for which consent is sought against it, not for it. The need for CPR is the only situation which imposes an apparent duty on health professionals to discuss a futile treatment without request from the patient, and equally, a situation where health professionals appear relieved of the obligation to discuss a treatment they plan to implement, as with non-futile CPR (Thorns, 2000).

Cardiopulmonary arrest can be defined as when a person's heart and breathing stop, or, 'Loss of consciousness with absence of circulation, accompanied

by absent or gasping respirations' (Quinn, 1998). When this happens it is sometimes possible to reverse respiratory and cardiac arrest, using CPR which might include:

- repeatedly pushing down firmly on the chest
- using electric shocks to try and restart the heart
- 'mouth to mouth' breathing
- inflating the lungs through a mask over the nose and mouth or tube inserted into the windpipe. (BMA *et al.*, 2001)

The aims of CPR are to restart the heart and breathing to the extent that the body can support itself.

The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council UK (RCUK) have produced some very comprehensive guidelines concerning cardiac and respiratory resuscitation (BMA *et al.*, 2001). These guidelines state that resuscitation can be attempted on any person whose cardiac or respiratory functions cease; however, it must be accepted that failure of these functions is part of the dying process and for everyone there comes a time when death is inevitable. It is important therefore to identify those patients for whom cardiopulmonary arrest is caused by a terminal event, and for whom CPR would not be appropriate, in order to ensure that they have a dignified death.

The development of CPR itself has had some rather bizarre steps along the way. Resuscitation of the dead is a recurrent theme in ancient mythology, and artificial respiration by midwives helping newborn babies to breathe is documented in the Book of Kings (in the Bible). In the early ages the heat method was used to try and revive people, hoping to warm the cooling body and restore heartbeat and breathing; this involved placing hot coals on the victim's thorax. It proved successful in some cases of hypothermia and unconsciousness but not in victims of actual cardiopulmonary arrest. In the 1500s the bellows method became popular; this involved the use of fire bellows which were placed in the victim's mouth and used to inflate the lungs. The occasional success of this method led to the design of the bag-valve-mask resuscitators used today. However, the authorities at the time were not yet aware of the need to hyper-extend the airway in order to allow good air entry into the lungs, so the method was not as successful as it may have been. The early 1700s saw the use of the fumigation method, one which was at times successful but it is difficult to say why. It was initially used by the North American Indians and then by the American colonists and later introduced to England in 1767. The method involved filling the removed bladder of an animal with tobacco smoke and then blowing this smoke into the victim's rectum. In 1744 Tossach used mouth-to-mouth artificial respiration on a drowned person, but this method was abandoned in favour of more mechanical methods. In 1770 the inversion method became popular. This was when the victim's ankles were tied together with a rope, which was then fixed to a pulley. The victim was hoisted up by the

ankles and alternately raised and lowered in an attempt to get air in and out of the chest cavity.

In the late 1700s, societies for preventing sudden death began to appear throughout Europe, for example the Dutch Society for Recovery of Drowned Persons, founded in 1767, and the Royal Human Society in Great Britain, founded in 1774. These societies practised some of the resuscitation techniques of the time, such as laying the body over a wine barrel and rolling the thorax backwards and forwards to cause chest compressions (late 1700s) or placing the person on the back of a trotting horse so that the motions also reproduced chest compressions (early 1800s). This latter method was initially used by American lifeguards on the beaches but was stopped by the 'Citizens for Clean Beaches Campaigners', about 1815. In the early 1800s the Russians adopted the ice method, encasing the victim's body in ice and snow in the hope of slowing the body's metabolism. Unfortunately, the method omitted to cool the head, which is also needed in order to slow the body's metabolism.

The publication of Mary Shelley's book, *Frankenstein, or the Modern Prometheus*, in 1818 caused artificial respiration and CPR to disappear for many years. The story of a mad scientist bringing life to a dead body did nothing to enhance the image of CPR.

In 1898 Tuffier and Hallion performed open chest cardiac massage successfully and this then became the popular method of cardiac resuscitation until the 1950s. In 1899 Provost and Batelli used alternate-current open-chest cardiac defibrillation on dogs with induced ventricular fibrillation with success. In the early 1900s Crile described closed-chest cardiac massage and recognised the importance of achieving adequate coronary perfusion pressure, and also the value of adrenaline.

The increasing use of electricity in the early twentieth century allowed the development of defibrillation for ventricular fibrillation. High fatality rates among electrical workers lead Edison to support the development of an electrical defibrillator by Hooker, Kouwenhoven and Langworthy. Wiggers also made significant contributions to the understanding of the pathophysiology of ventricular fibrillation at this time. Beck reported the first successful case of open defibrillation in 1947, and Zoll reported successful closed-chest defibrillation using alternate current in 1956.

In the late 1950s doctors Safar and Elam demonstrated that mouth-to-mouth rescue breathing was superior to the mechanical techniques previously used. The interest in closed-chest cardiac massage was rekindled around this time as well. Bahnson successfully used this technique to resuscitate a small child in 1958, and in the 1950s the US military began an aggressive public campaign on the use of mouth-to-mouth resuscitation, which they had used successfully in World War Two. American lifeguards were instructed on how to perform mouth-to-mouth resuscitation whilst in the water, using flotation aids.

Further research was carried out on cardiac defibrillation in the 1960s. Dr Frank Partridge was responsible for the first portable defibrillators being put

into ambulances in 1963: at that time they were size of a small refrigerator, and difficult to use (hard to believe as today defibrillators are easily portable, and increasingly available for use by the public).

CPR as we know it today was fully developed by Kouwenhoven *et al.* in 1960, and combined mouth-to-mouth resuscitation, defibrillation and closed-chest cardiac massage. This research was fully reported in the *Journal of the American Medical Association* (JAMA) in 1960. The article outlined the crucial aspect of this whole technique (using either open- or closed-chest cardiac massage), which was that the patient received oxygenated blood that would then be transported to the brain by minimal blood circulation, reducing anoxia and its effects on the brain and body. It described the team's previous research on closed-chest compressions in cats and dogs and the noted positive blood pressure changes this technique induced. This method was then applied to humans, the anatomy of the thorax lending itself to such chest compressions: the sternum, vertebrae and ribs provide an enclosed area with support, allowing the heart to be compressed when pressure is applied correctly, and then to relax when this pressure is removed, thus allowing the heart to fill with blood again. This method was also meant to allow some lung ventilation and the article advocated concentrating mainly on the chest compressions if a person was attempting CPR on a patient by themselves. This method of CPR was trialled at the John Hopkins Hospital, in the USA, over a nine-month period. Twenty patients, aged between two months and 80 years, were all resuscitated successfully, and 14 of them lived to the time the article was written 10 months later. Five cases were reported in detail, four of which needed resuscitation during surgery and one of which was admitted to the emergency room in ventricular fibrillation. There are no details given of which of the 20 patients survived, or anything to suggest why.

On the surface, CPR sounded fantastic: the answer to every doctor's need, helping them to overcome death and disease more than ever. Unfortunately, all the cases reported were sudden, traumatic events, nothing to do with palliative care or death from terminal illness. The application of this method of CPR so readily to nearly all areas of medicine is frighteningly intense, and has probably been influenced heavily by medical paternalism (i.e. medical staff take the dominant role in care and treatment decisions). Ironically, at a similar time, Dame Cicely Saunders was one becoming of the first pioneers of palliative care, and the hospice movement.

In the 1970s CPR was introduced to the public, and in the past few years it has been added as mandatory to all first aid training as well as to all medical and nurse training, with mandatory yearly updates required of all clinical staff. It is available world wide and resuscitation teams are found in every general hospital. It is a widely accepted and expected management of cardiac arrest, and is regulated and advised by the Resuscitation Council in the UK, Europe and worldwide. These councils work in conjunction with medical and nursing

councils worldwide in order to update CPR guidelines and training as required.

The history and development of CPR provides some insight into its ongoing importance in medicine; however, this must be balanced with appropriate use, likely success and possible side effects.

2 CPR versus active treatment in palliative care

Cardiopulmonary resuscitation (CPR) includes mouth-to-mouth resuscitation, closed-chest cardiac massage and defibrillation. The aim of CPR is to support the body's circulation to prevent the effects of anoxia until the circulation can be restored, or until such efforts are seen to be futile. However, there are other medical treatments and interventions which can be used to support these body systems if they begin to weaken, but which will not support cardiac and respiratory function if it has ceased altogether (BMA *et al.*, 2001). These are collectively known as 'active treatment', and they include many things to try and prevent the function of the heart and lungs from ceasing, such as antibiotics, intravenous fluids, diuretics, blood transfusions and so on. Active treatment may be appropriate in situations where CPR is not, or when it has been refused. When discussing CPR with patients and their family carers it is important that the distinction is made between CPR and active treatment. Explanations should be given that 'Do Not Attempt Resuscitation' (DNAR), sometimes called 'Not for Resuscitation' (NFR), does not mean 'no treatment'.

Even if active treatment is not appropriate for certain patients, palliative care and good, supportive, holistic nursing care can often reassure patients and their family carers, and reinforce the importance of a dignified 'good' death. To prevent confusion the resuscitation guidelines suggest that one phrase is used when patients are 'not for resuscitation': 'Do Not Attempt Resuscitation' (DNAR) and that other phrases are used when considering active or alternative treatment. The guidelines are corroborated by the American Medical Association.

Willard (2002) argues that there is a lack of clarity about what palliative care is, and this is coupled with our increased ability to extend life. This situation seems to be creating substantial and unacknowledged difficulties for some healthcare professionals. For example, Willard says that healthcare professionals could question the extent to which they are able to reconcile two sometimes conflicting aims: the desire to extend survival by providing what can be quite aggressive treatment and the desire to promote a good quality of