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Cardiopulmonary resuscitation knowledge and opinions on end of life decision making of older adults admitted to an acute medical service

Rupali Sharma, Sisira Jayathissa, Mark Weatherall

ABSTRACT

AIM: To determine the knowledge in cardiopulmonary resuscitation (CPR) process, preference for CPR, and desire to participate in end-of-life decision making amongst older hospitalised patients.

METHOD: We prospectively interviewed 100 participants above 65 years of age awaiting discharge from acute medical ward and collected demographics, knowledge of CPR and opinion on CPR in various clinical scenarios.

RESULTS: Amongst the participants, 58% had good understanding of all components of CPR and 91% overestimated its success. Fifty-eight percent wished to have CPR in current health status, but this declined if they were presented a hypothetical scenario of critical illness (46%), functional impairment (17%), terminal illness (13%) and dementia (13%). Tertiary education, male gender and not living alone were associated with accepting CPR. Ninety-three percent were comfortable discussing CPR and 84% felt comfortable documenting their wishes in the medical notes. Seventy percent wished such discussion to include themselves and their family.

CONCLUSIONS: Older inpatients have a reasonable understanding of the components of CPR and wish to be involved in CPR decision-making. Clinical scenarios with poor prognosis may lead to patients declining CPR. Discussion and documentation of resuscitation wishes is useful in routine assessment process among elderly hospitalised patients.

End-of-life issues are important to health care practitioners, patients and the general public, and are often reported in the media. Some media reports include discussions about blanket age-related approaches to Do Not Resuscitate (DNR) orders, high-profile court cases involving patients with incurable diseases wishing to exercise a right to die, and about physician-assisted suicide. There is a perception of the widespread use of inappropriate resuscitation and lack of patient autonomy. In response to this, DNR policies have developed over the last two decades in most health care institutions. These policies intend to provide clear clinical guidance for staff to administer appropriate levels of care for unfamiliar patients, and enable them to implement the principle of minimising harm to patients.

It is likely that many people get information on cardiopulmonary resuscitation (CPR), its administration, success rate, and lack of adverse events from the media. Medical television dramas usually portrays CPR as a very successful procedure without adverse effects. According to Diem and based on previous studies, 70–94% of older adults get information about CPR from television. In that study analysing three television dramas, Chicago, ER and Rescue 911, the survival rate of CPR was 62%, about five times higher than a meta-analysis estimating survival to discharge after CPR in ICU at
The general public may not know that in some groups of patients CPR is completely ineffective. In a prospective cohort study of 294 patients who were resuscitated in a teaching hospital after cardiac arrest, a number of factors predicted increased mortality after CPR. These included pneumonia, hypotension, renal failure, cancer, and a homebound lifestyle before hospitalisation. None of 58 patients with pneumonia, or 179 patients for whom resuscitation took longer than 30 minutes, survived to be discharged from hospital.

Patient and community attitudes and knowledge about CPR may change over time. O’Keeffe and colleagues conducted a study in 1992 in an Irish hospital and observed that 39% of patients felt it was a good idea for doctors to discuss CPR. However, in their current health, 76% would refuse CPR. Subsequently, Cotter and colleagues reported a 15-year follow-up study in 2007, which found that most hospitalised patients (94%) felt it was a good idea for doctors to discuss CPR routinely with patients. In their current health, 6% of the 2007 cohort would refuse CPR.

The ability to gain informed consent from older, unwell adults can be challenging for health professionals. This poses an ethical dilemma between autonomy and the principles of ‘do no harm’. Russell and colleagues report about provision of information of CPR amongst older inpatients and assessing their ability to make a decision. One hundred consecutive patients admitted to an assessment and rehabilitation unit for the elderly in Dunedin, New Zealand, were randomly allocated to receive a detailed discussion on CPR, or to act as controls. Subsequently knowledge about CPR was tested in both groups. After the interview, knowledge about CPR was significantly improved in the study group compared to the controls, indicating that careful explanations assist in making an informed decision.

Advance care planning is gaining momentum throughout developed world. It is promoted as a way to help patients think about, talk about, and share their thoughts and wishes about their future health care and encourages documenting them. With active promotion of advance care planning, it is likely that health professionals have to get actively involved in discussing many aspects of advance care planning, including CPR. However, there is relatively insufficient information about patient attitudes towards advance care planning, especially CPR.

It is likely that attitudes to CPR in New Zealand have changed over time. The aim of this study was to determine contemporary knowledge in an older New Zealand hospitalised patients about preferences for CPR and their wish to participate in end-of-life decision making.

Methods

We conducted a prospective study between April 2011 and May 2012 in the medical and cardiology wards of Hutt Hospital, a secondary-care hospital with a catchment population of around 150,000. Eligible participants were older than 65 years of age, medically stable, and waiting to be discharged after their acute admission. We excluded patients with significant cognitive impairment, delirium, severe depression, were unable to complete the survey in English, had other severe communication problems, or terminal illness receiving palliative care. We identified potential participants by discussions with the admitting medical team, and an initial verbal consent was sought. Every
patient underwent Folstein’s mini-mental score and we excluded patients with score below 24. The status of delirium, severe depression, communication problems and terminal illness were determined by the medical team and review of the notes.

A study questionnaire was prepared based on a literature search for published articles on CPR studies and the questions used in those studies. A pilot study was conducted on 10 participants, which included 5 patients and 5 health professionals, to test the adequacy of the questionnaire. The feedback from the participants was incorporated in finalising the questionnaire.

We provided an information sheet outlining the study objectives to the willing participants. After obtaining written informed consent, one of the investigators (RS) administered the study questionnaire about CPR to each patient. This ensured there was no variation in information presented to participants. Family members were encouraged to be present during the interview. The first part of the questionnaire contained questions about CPR issues, which included: whether anyone has discussed cardiopulmonary resuscitation with them—if yes, who had the discussion; their preferences to receive CPR; and its success rate, as they perceived it. The success rate of survival after CPR in the hospital had 6 predetermined options: less than 1%; 1–5%; 5–10%; 10–25%; 25–50%; and 50–100%. The participants' knowledge about CPR procedures included questions about the components of CPR, such as chest compression, placing a tube in the throat to help breathing, electrical shocks to start the heart, and giving fluids via an intravenous line. The first part of the questionnaire was followed by the provision of written information on CPR process and verbal explanation including its success rate in general (Appendix 1). The second part of the questionnaire included questions to evaluate the patient's wishes to receive CPR in their current state of health, and their preference in four hypothetical situations: critical illness; terminal illness; severe disability; or severe dementia. Participants could have four response choices for each situation: to have CPR; not to have CPR; to allow the doctors to decide; or to allow their relatives decide. We also asked questions about DNR orders and who should make these. The questionnaire is included in Appendix 2.

We collected data, including basic demographic information about age, sex, ethnicity, educational status, religion, and living situation. We obtained information about the presence and types of chronic diseases and participants' functional status from the medical records.

Simple summary statistics were used to describe the participants. The proportion of participants who reported they would like CPR under the various scenarios is shown, together with exact binomial confidence limits. Logistic regression was used to evaluate the strength of association between participant characteristics and whether they wished CPR to be performed in their current state of health. SAS version 9.3 was used. A sample size of 100 was chosen to provide a margin of error (95% confidence interval) for a proportion of plus or minus 10%.

The study was approved by the Hutt Hospital Research Committee, including the Maori Health Unit at Hutt Hospital, as well as the Central Regional Ethics Committee; Ethics Reference CEN/11/03/009.

Results

The characteristics of the 100 study participants are shown in Table 1. The mean age of participants was 81.5 years, with a range from 65 to 98 years. There were 50 men and 50 women. The majority (78%) were Christian, and 92% were New Zealand European. Forty-five percent lived alone. The median Charlson Comorbidity index score was 5. Twenty-three percent of participants had tertiary education.

Resuscitation preferences in participants' current state of health, and the four hypothetical situations following provision of information on CPR, are shown in Table 2. Fifty-eight percent wanted resuscitation at current state of health. This proportion declined progressively with critical illness (48%), functional impairment (17%), to terminal illness and cognitive impairment (13% each).

Thirty-two participants reported that they had previous discussions on resuscitation;
Table 1: Description of participants.

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>N/100 (%)</th>
</tr>
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<tbody>
<tr>
<td>Age (years)</td>
<td></td>
</tr>
<tr>
<td>65–74</td>
<td>44 (44)</td>
</tr>
<tr>
<td>75–84</td>
<td>35 (35)</td>
</tr>
<tr>
<td>85+</td>
<td>21 (21)</td>
</tr>
<tr>
<td>Female Sex</td>
<td>50 (50)</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>78 (78)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (4)</td>
</tr>
<tr>
<td>No belief</td>
<td>18 (18)</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>10 (10)</td>
</tr>
<tr>
<td>Secondary</td>
<td>67 (67)</td>
</tr>
<tr>
<td>Tertiary</td>
<td>23 (23)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>New Zealand European</td>
<td>92 (92)</td>
</tr>
<tr>
<td>New Zealand Māori</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Living arrangement</td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>45 (45)</td>
</tr>
<tr>
<td>With a partner</td>
<td>39 (39)</td>
</tr>
<tr>
<td>With family</td>
<td>11 (11)</td>
</tr>
<tr>
<td>Rest home</td>
<td>5 (5)</td>
</tr>
<tr>
<td>Other continuous variables</td>
<td></td>
</tr>
<tr>
<td>Median (Range)</td>
<td></td>
</tr>
<tr>
<td>Charlson Score</td>
<td>5 (4–10)</td>
</tr>
<tr>
<td>Number of Chronic conditions</td>
<td>4 (2–9)</td>
</tr>
</tbody>
</table>

Table 2: Proportion of participants who would request cardiopulmonary resuscitation by different scenarios, after provision of information on CPR.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Number seeking CPR</th>
<th>Percentage (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Health</td>
<td>58/100</td>
<td>58 (47.7–67.8)</td>
</tr>
<tr>
<td>Critical Illness</td>
<td>46/100</td>
<td>46 (36.0–56.3)</td>
</tr>
<tr>
<td>Terminal Illness</td>
<td>13/100</td>
<td>13 (7.1–21.2)</td>
</tr>
<tr>
<td>Functional Impairment</td>
<td>17/100</td>
<td>17 (10.2–25.8)</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>13/100</td>
<td>13 (7.1–21.1)</td>
</tr>
</tbody>
</table>
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Table 3: Predictors of the wish to have Cardiopulmonary Resuscitation in participant's current state of health.

<table>
<thead>
<tr>
<th>N/N (%)</th>
<th>Desires CPR versus Not or Unsure</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Univariate</td>
<td>Multivariate</td>
</tr>
<tr>
<td>Age</td>
<td>65–74</td>
<td>75–84</td>
</tr>
<tr>
<td></td>
<td>26/44 (59)</td>
<td>20/35 (57)</td>
</tr>
<tr>
<td>Education</td>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td></td>
<td>3/10 (30)</td>
<td>35/67 (52)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>New Zealand European</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>52/92 (57)</td>
<td>6/8 (75)</td>
</tr>
<tr>
<td>Living situation</td>
<td>Alone</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>23/45 (51)</td>
<td>35/55 (63)</td>
</tr>
<tr>
<td>Religious belief</td>
<td>Christian or other</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>47/82 (57)</td>
<td>11/18 (61)</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>34/50 (68)</td>
<td>24/50 (48)</td>
</tr>
</tbody>
</table>

12 with a doctor, 11 with a family member and 9 with a nurse outside hospital. The majority of participants, (86/100) reported they understood at least part of the process of CPR. Of those who felt they understood the process, 52% were aware of all four components of the process, 6% knew about three major components, and 15% knew about chest compression. Forty-four participants estimated the success rate of CPR between 50 and 100%, 24% between 25 and 50%, 23% between 10 and 25%, and 7% between 5 and 10%. None of them scored below 5%.

Seventy-four percent of participants wanted the doctor to make the decision regarding CPR with consultation with them and their family, of which 48% preferred the hospital doctor over their GP (26%). Nineteen percent felt that a decision on CPR should be made only by their family. Seventy percent wanted that doctor to make the decision after discussing with the family if the prognosis was poor.

Sixteen percent of participants did not want any kind of documentation about CPR, 49% wanted documentation of their CPR preferences in their medical notes, 16% in their discharge summary, 18% wanted documentation in advance care plan and 22% wanted documentation in medical notes, as well as in advance care plan. Altogether, 40% considered an advance care plan.

About 62% felt that it was a good idea to discuss CPR with any patient. 7% of
the patients felt uncomfortable with the interview and reported feeling distressed with the discussion of CPR. Associations with preference for CPR in the participants’ current state of health are shown in Table 3. In univariate analysis, a higher level of education and being of male sex predicted the wish to have CPR. Age, ethnicity, living alone or religious beliefs were not associated with the wish for CPR. On multivariate regression, only a higher level of education was associated with the wish to receive CPR.

Discussion

The knowledge regarding CPR process has improved in general amongst the elderly population (86% in this study) compared to that in a 1997 New Zealand-based study (53%). Over recent years, there has been an increase in openness about the discussion of resuscitation issues by doctors with their patients. Despite this, our study shows that CPR was discussed with them by medical or nursing staff in 21% of the patients, while 11% of patients had discussions of CPR with a family member. This is in spite of nearly three-quarter of patients keen to make some form of decision regarding their CPR status. Sensitivities around dying and unavailability of time may have been a contributing factor preventing such discussions. However, we did not specifically focus on this issue in our study, and this theme could be explored in further studies.

Overestimation of the success rate of CPR prevailed amongst the elderly patients, as shown in other studies. The majority of the participants in the 1997 New Zealand study estimated success rate as over 50%, whereas in this study 91% estimated the success rate as ranging between 10%–100%, which is unrealistic in our population. Only half of the patients understood all 4 components of CPR. It is possible that patients may have a simplistic attitude, that CPR could ‘start the system again’, as seen on television. Even though our classification of 4 components of CPR is arbitrary, we feel it is important for patients to be fully informed by clinicians about the whole process of CPR in making CPR decisions and in advance care planning.

The preference for CPR was generally high in all age groups considering their current state of health. However, once they were educated about the CPR, their likelihood of wishing resuscitation declined from critical illness through terminal illness or severe physical disability to dementia. The preference for CPR in current status of health was low (58%) compared to the previous 1997 New Zealand study (79%) and an Irish study in 2007. In all four clinical scenarios, New Zealand participants had a lower preference rate compared to Irish participants—critical illness (46% vs 55%), terminal illness (13% vs 37%), functional impairment (17% vs 33%), dementia (13% vs 25%). The reasons behind these differences are unclear, but could be due to cultural, spiritual, educational and/or religious factors. This finding also suggest informed elderly New Zealand patients make rational decisions about their options on CPR.

Our study showed that the majority of older people desire themselves or their family to be involved in decision making in relation to CPR. In the event that they were not in a state to make a decision, they wanted the doctor to make the decision in consultation with their family. In New Zealand, the decision to resuscitate is treated as a medical responsibility like any other treatments, but shared decision making could always reduce potential conflicts. Older patients appeared to appreciate the importance of documenting their wishes in any form, either in their medical notes, discharge summary, or in an advance care plan. This reflects an increasing awareness of CPR issues and understanding the value in documenting their wishes, especially with advance care planning in the community.

Older adults in general were very open about discussing CPR and felt very comfortable with the discussion. This corresponds with the findings of other studies. However, there was a small minority of patients who felt very distressed by the discussion. Clinicians should be mindful about these patient’s sensitivities when entering into such discussions.

We found no association between older age, religion, or comorbid illnesses, and preference for CPR. However, those who are less likely to refuse CPR are male, educated and not living alone. This is in contrast to the Irish study, where those with disability,
or those with religion (other than Catholicism) wished not to have CPR. Although in our study there was trend for more educated subjects to be less likely to refuse CPR, we were not able to explain the reason behind higher education having a positive influence on the patient’s desire for CPR. It is possible that as education provides a positive outlook, people are ready to take on the small chance of success. Interestingly in the 1997 New Zealand study, those who did not want CPR tended to be single, older, living alone or in care, and be female. This difference could not be explained rationally.

There were several limitations to our study. Different ethnic groups were poorly represented, and as a result comparisons could not be made between ethnic groups in terms of CPR preferences. This is partly because very few adults above the age of 65 years were Māori or Pacific Islanders or from other ethnic communities and met the inclusion criteria for the study. This study was also conducted in a group of relatively well inpatients and may not accurately reflect the opinion of patients in their sick-dependent state. The study topic is sensitive and recruitment was unexpectedly difficult for the study, and patients who volunteered may have been more comfortable in discussing the CPR.

We obtained perceived success rates of CPR only before providing information on CPR and repeating the success rate may have influenced the patient’s knowledge of success. The same interviewer interviewed all the participants, thus reducing inconsistency around the interview process. It would be useful to repeat this study in a wider range of ethnic and cultural groups.

In spite of the limitations, our study provides useful information on contemporary thinking of CPR among older New Zealand adults and gives some useful guidance to health professionals about the expectations on shared decision making.

**Conclusion**

In summary, this study shows that a substantial number of older adult patients would like CPR. However, this declines with the severity of the illness in our hypothetical scenarios. A more systematic approach to the provision of information and discussion of CPR, and advance care planning in the wider community as well as in hospital settings, is likely to promote better decision making for patients and health professionals. Further research in this area may help in the development of sound advance care planning strategies.

**Appendix 1**

**Information on Cardio Pulmonary Resuscitation (CPR) to patients**

We have compiled the following information to give you some background knowledge on Cardiopulmonary Resuscitation.

Cardiopulmonary Resuscitation (CPR) is performed when a person’s heart or lungs stop working suddenly. The circulation is kept going by pressing up and down on the chest. In order to get air into the lungs, mouth to mouth breathing or a tube is inserted into the throat. Electrical shocks are often used to restart the heart. Some patients come around immediately, but others may need to spend some time on a ventilator - a machine to help keep the person breathing. Most patients will need a drip to give fluids into the veins and most will spend some time in the intensive care or coronary care unit.

Some of the patients who initially are kept alive by resuscitation efforts may die before they can be discharged. Chances of death are higher if the patient has significant medical problems such as heart failure, kidney failure, chronic lung disease, or terminal illness. Some may develop brain damage which could be permanent. Few could recover and go home if resuscitation was successful.

Various studies on survival after in-hospital CPR have showed overall likelihood of surviving discharge as 1 in 8 (13%) for patients who undergo CPR and 1 in 3 (33%) for patients who survive CPR. However in patients with multiple medical problems, survival may be close to zero.

In one study of 294 patients who underwent CPR, none of the 58 patients with pneumonia and none of the 179 patients in whom resuscitation took longer than 30 minutes survived to be discharged.
Appendix 2
Date: 29 March 2011, version 2.

Questionnaire
Patients’ understanding of resuscitation process and views on end of life decision making
Thank you very much for answering the questionnaire. You may discuss with your friends / family members / whanau before answering any question. Please feel free to discuss with the Study doctor if you have any questions to clarify or if you have any concerns.

Part A: General information
Please tick the boxes that apply to you.

1. Which age group do you belong to?
   - 65–74 years
   - 75–84 years
   - 84 years and above

2. What is your gender?
   - Male
   - Female

3. Which ethnic group(s) do you identify yourself with?
   - NZ Maori
   - NZ European
   - Pacific Islands (Fijian, Nioeuan, Tongan, Cook Islands, Tokelauan, Samoan, other)
   - Chinese
   - Southeast Asian
   - Indian
   - Middle Eastern
   - African
   - Others (specify your ethnicity)

4. What is your religious belief?
   - Christianity (you could define branch of Christianity you follow if you wish).............
   - Islam
   - Jewish
   - Hinduism
   - Buddhism
   - No religious belief
   - Others (please specify)

5. What is your highest educational qualification?
   - Primary school
   - Secondary School
   - Tertiary Technical College or University

6. What is your living situation?
   - With Partner
   - Alone
   - With other family member(s)
   - Other arrangements (Rest Home, Hospital level care)

7. Has anyone discussed Cardio Pulmonary Resuscitation (CPR) status with you before?
   - Yes
   - No

8. If you had previous discussions on Cardio-Pulmonary Resuscitation (CPR), with whom did you discuss it?
   - Medical doctor at Hutt Hospital
   - Your own General Practitioner (GP)
   - Nurse or another health professional at Hutt Hospital
   - Nurse or another health professional outside Hutt Hospital
   - Member of your family
   - Not applicable

9. Do you understand what is meant by Cardio-Pulmonary Resuscitation (CPR)?
   - Yes
   - No

10. In your opinion, which of the following may be carried out during Cardio Pulmonary Resuscitation (CPR)?
    - Chest compression to pump blood
    - Placing a tube in the throat to help breathing
    - Giving electrical shocks to start the heart
    - Giving fluids by a drip to the veins to maintain circulation
    - All of the above
11. In your opinion what is the chance of surviving after Cardio-Pulmonary Resuscitation (CPR) performed in Hospital?

- Less than 1%
- 1–5%
- 5–10%
- 10–25%
- 25–50%
- 50–100%

Part B: Information on CPR provided

12. Given your current health status what is your preference on Cardio Pulmonary Resuscitation (CPR)?

- I would wish to receive CPR.
- I would wish not to receive CPR.
- I am not sure.

13. Please consider the scenarios outlined below and for each scenario please choose any one of the 4 options listed below?

Scenario 1: If you had a critical illness (ie, requiring hospital admission and treatment with drips where the outcome may be unclear)

Options:
- I wish to have Cardio-Pulmonary Resuscitation.
- I do not wish to have Cardio-Pulmonary Resuscitation.
- I wish my doctor to decide on Cardio-Pulmonary Resuscitation.
- I wish my relatives to decide on Cardio-Pulmonary Resuscitation.

Scenario 2: If you had a terminal illness (eg, Cancer, where you are likely to die within 6 months regardless of any treatment)

Options:
- I wish to have Cardio-Pulmonary Resuscitation.
- I do not wish to have Cardio-Pulmonary Resuscitation.
- I wish my doctor to decide on Cardio-Pulmonary Resuscitation.
- I wish my relatives to decide on Cardio-Pulmonary Resuscitation.

Scenario 3: If you had a severe physical disability like a stroke (ie, requiring assistance with mobility, feeding, transfers, toileting etc...)

Options:
- I wish to have Cardio-Pulmonary Resuscitation.
- I do not wish to have Cardio-Pulmonary Resuscitation.
- I wish my doctor to decide on Cardio-Pulmonary Resuscitation.
- I wish my relatives to decide on Cardio-Pulmonary Resuscitation.

Scenario 4: If you had severe dementia but were otherwise in good physical health (ie. severe, irreversible confusion and memory loss, but otherwise in good health)

Options:
- I wish to have Cardio-Pulmonary Resuscitation.
- I do not wish to have Cardio-Pulmonary Resuscitation.
- I wish my doctor to decide on Cardio-Pulmonary Resuscitation.
- I wish my relatives to decide on Cardio-Pulmonary Resuscitation.

14. What are your thoughts on doctor making Do Not Resuscitate (DNR) decisions in consultation with your family/partner?

- Resuscitation decisions should be done by my family doctor when I am in good health, considering all aspects of my health.
- Resuscitation decisions should be done by the hospital doctor as they know my health status best if I am very unwell.
- My family would make a better decision than my doctor because they are better informed about my health and life.
- It is a sensitive topic and I feel uncomfortable discussing it with my family or doctors.

15. Do you think your doctor should be able to make a decision regarding Cardio Pulmonary Resuscitation (CPR) without consulting you or your family if they thought the outcome was likely to be very poor?

- I think my doctor should make the decision without consulting me or my family.
- I think my doctor should make the decision in consultation with me or my family.
16. When a decision to Do Not Resuscitate (DNR) is made, it is routinely documented in your medical notes. What are your thoughts on this?

- I think my family should make the decision.
- I am not sure.
- Any other comments.

17. What are your thoughts about doctors discussing Cardio-Pulmonary Resuscitation (CPR) with every patient admitted to the hospital?

- I think discussing CPR with every patient on admission is a good idea.
- I think discussing CPR with every patient on admission is a waste of time.
- I think this is a sensitive area and could cause distress to the patient. Discussing CPR could negatively affect patient's health.
- Any other comments

18. Have you found this discussion upsetting or distressing?

- Yes
- No
- Any other comments

19. What are your thoughts on Cardio Pulmonary Resuscitation (CPR) in general?

- Any other comments

Competing interests: Nil

Author information:
Rupali Sharma, Internal Medicine, Wellington Hospital; Sisira Jayathissa, Medicine, Hutt Valley DHB; Mark Weatherall, Medicine, University of Otago Wellington

Corresponding author:
Rupali Sharma, Internal Medicine, Wellington Hospital
rupali.sharma@ccdhb.org.nz

URL:
REFERENCES:


