Resuscitation Discussion Guide
Based on a study of patients’ experiences with resuscitation discussions, funded by the Allina Foundation.

1. Many patients fail to recall these discussions. Consider an ongoing written summary of the discussion and decision.

2. Patients often:
   - want to talk about resuscitation
   - have clear opinions about resuscitation choices
   - do not remember resuscitation discussions
   - need respect and attention, even more than a long relationship, for a good discussion

When: Preferably when healthy or soon after diagnosis
Where: Private, quiet, preferably outpatient setting
Who else is present: Family, friend, spiritual counselor, other professional or no one, as patient requests
How to start:
   - “With all my patients, I always try to discuss their desires about resuscitation...” or
   - “To follow your wishes, I want to know how you want me to take care of you...” or
   - “Let’s talk about your goals for treatment, what you want us to do and why...”

Medical information:
   - Summarize medical condition
   - Describe medical scenarios when the patient may have cardiac or respiratory arrest
   - Describe resuscitation procedures, including definitions, as the patient is capable of understanding
   - Describe statistics on outcomes of CPR if patient desires them

3. Select factors that are important to the patient:
   - Experience with difficult end-of-life decisions for family/friends
   - Religious beliefs
   - Previous conversations with significant others
   - Level of ability to function independently pre- and post-resuscitation
   - Cultural influences, e.g., mistrust of health care systems

Personalize the DNR order:
   - Recognize that the patient may elect to specify the resuscitation procedures to be used, e.g. “I want you to try a ventilator if I stop breathing but do not attempt to start my heart beating.”
   - Recognize that patients may have conditional situations, e.g. stricture, where they would limit the application of CPR or the length of prolonged therapy they would want, e.g. mechanical ventilation
   - Describe DNR order rescissions, e.g. surgery

4. Express:
   - Do-not-resuscitate orders do not preclude other kinds of treatment or attention
   - The decision can be changed at any time

Repeat:
   - Verify resuscitation decisions at each change in level of care, (acute, long term, and home) because of patient tendency to forget
   - Repeat appropriately as condition changes

Document:
   - Ensure that written description of resuscitation discussion, patient’s decision, and any resulting orders are documented according to institutional policy

***Patient scenarios —
Hospital — You have severe emphysema and your lungs are failing. At some time, we may have to decide whether to use a breathing machine. We will be able to keep you comfortable without the breathing machine or we could use a breathing machine and comfort measures to prolong your life.

Nursing home — You are in your nursing home, and your heart stops. A nurse finds you, what should she do? Should she try resuscitation measures?

****Description of resuscitation procedures
CPR (cardiopulmonary resuscitation) — If the heart or lung manual pressure to the chest, artificial breathing, drugs and electric shock to the chest may restore heart function

Mechanical respiration — If the lungs do not work adequately, mechanical respiration can take over breathing and provide oxygen through a tube down the throat.

In either case, transfer to an intensive care unit and prolong inpatient care will be required.

****Resuscitation survival statistics
These statistics are significantly affected by the patient’s underlying conditions, i.e., survival is lower with cancer, sepsis, failure, e.g. These statistics do not apply to patients with simple myocardial infarction who are being monitored.

| In-hospital arrests | 3-15% survival to discharge from hospital |
| Long term care arrests | 1-2% survival to discharge from hospital |
| Out-of-institution arrests | 4-38% survival to discharge from hospital |

Note: This counseling guide is for use with persons with intact decision making capacity.

Patients with decision making capacity can:
   - understand treatment benefits/risks
   - make a treatment decision
**DECISION MAKING**

- **patient with capacity**
  - can make all decisions, including:
    - refuse any treatment
    - refuse any test
    - discontinue any treatment
  - can consent to DNR (Form #1)

- **patient without capacity**
  - **with surrogate or Proxy**
    - surrogate or Proxy can agree to any recommended treatment or test
    - can make choices between medically appropriate options
  - **without surrogate**
    - with oral or advance written directive
      - follow patient's directions
    - without advance directive
      - presume that patient wants to be treated and to live
      - issue DNR order only resuscitation medically futile (Form #6)

- **Proxy**
  - may refuse instituting or continuing life sustaining treatments or tests and, with knowledge of patient's prior wishes, may even refuse nutrition or hydration
  - Proxy can consent to DNR (Form #4)

- **Surrogate**
  - may refuse instituting or continuing life sustaining treatment, including nutrition or hydration, *only* with written or oral clear and convincing evidence of patient's prior wishes
  - Surrogate can consent to DNR if:
    - patient is in a terminal condition
    - CPR would be medically futile
    - CPR would be an extraordinary burden on patient (Form #5)