



Cardiopulmonary Resuscitation in the Frail Elderly: Clinical, Ethical and Halakhic Issues*

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Abstract

Cardiopulmonary resuscitation is an emotion-ridden issue that often leads to conflicts when crucial decisions have to be made. The purported benefits of this 40 year old procedure in the frail elderly have been scrutinized, establishing its lack of efficacy. A review of the medical, ethics and halakhic* literature on the potential merits of CPR in the frail elderly revealed that in secular medical practice, CPR is often routinely provided to elderly frail individuals for whom its clinical benefit is questionable. For patients suffering from dementia, surrogates are usually responsible for decision making, which complicates the process. With such poor clinical outcomes, the halakhic interpretation of what steps should be taken, and currently are, may not be valid and CPR may be applied too frequently. When clinical ambiguity is combined with strong cultural and religious influences, an acceptable CPR/DNR (Do Not Resuscitate) approach to cardiac arrest can be daunting. A clinically responsible, ethically sound and religiously sensitive approach to CPR requires a deep understanding of the factors involved in decision making. It seems timely for the halakhic interpretation of the duty to provide CPR in the frail elderly to be reevaluated. Perhaps a more humane and halakhically sound approach might be reached by stringently limiting CPR to clinically unusual circumstances rather than the common practice of providing frail Jewish elders with CPR in the absence of a DNR order.

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The numerous clinical and psychosocial needs of the frail elderly who require long-term care present their caregivers – family and professionals – with many challenges. This is particularly true in emergencies. Ethical issues in the realm of end-of-life decisions and potentially life-ending events such as cardiac arrest are of special interest [1], primarily to those whose religion embraces the sanctity of life. During the last 30 years, in North America and much of the western world, ethical deliberation has been based primarily on secular values, as described by Beauchamps and Childress in their development of Principlism [2].

In many western countries, as in Israel, a large proportion

of the population has strong ethnic and religious beliefs. These values often provide a counterbalance to secular perspectives in ethical decision making regarding complex clinical situations such as cardiopulmonary resuscitation. For those elders, their families and other surrogates with strongly held religious beliefs, it is expected that in the decision-making process healthcare professionals understand and respect these values. This is especially the case regarding issues of life and death. The decision-making process is often complicated by the diverse and sometimes conflicting religious views that may impact on family members, patients and healthcare professionals [3-5].

Healthcare decisions, CPR and *Halakha*

For the Jewish elderly, whether they reside in Israel or the Diaspora, healthcare decision issues, especially those at the end of life may be affected by halakhic interpretations, depending on the degree of orthodoxy of the patient and the family [6-11]. Halakhic values have a long history of development, interpretation and reinterpretation. Their impact on medical deliberation and clinical decision making, especially in end-of-life or potentially life-ending situations, for those who follow Judaic practices and principles is substantial. This is particularly true in Israel where Judaic tenets influence all medical decisions, policies and practices.

Halakhic interpretations are critical, especially when decisions about life and death are at stake. Frequently, local laws or individuals' personal values and decision-making options may conflict with *Halakha*, leading to tension and disagreement regarding the treatment. Institutional policies may result in potential conflicts depending on the particular jurisdiction (especially in the Diaspora), the extent to which the policy is based on secular or religious values, and how it affects individuals across the spectrum of Jewish religious belief and observance. There might be differences in the way medical practices are implemented in the Diaspora and in Israel, even within a framework of respect for religious beliefs.

In a medical emergency, irrespective of the cultural, societal or religious context in which medicine is practiced, there is usually an overriding obligation to save the life potentially at risk. This is congruent with most secular principles as well as with *pikuah nefesh*, the halakhic principle of saving a life because *all* life is sacred. CPR

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** Pertaining to *Halakha*, the corpus of Jewish law
CPR = cardiopulmonary resuscitation

is an example where the normal clinical obligation to respond to an apparent cardiac arrest generally results in immediate CPR. It is assumed that by restoring cardiac and pulmonary function it may be possible to prevent what would otherwise be imminent death. The process assumes that the underlying condition that precipitated the cardiac arrest is potentially reversible; otherwise the activity would be clinically futile. In most western jurisdictions, in the absence of a specific refusal to receive CPR via a legally mandated option of DNR (Do Not Resuscitate), physicians and nurses are generally obligated to provide CPR until success or failure is determined.

The frail elderly population

During the past 15 years, the data relating to CPR in the frail and chronically ill elderly suggest that we revisit the underlying assumptions and standard protocols. Perhaps the usual paradigm of CPR unless refused through a DNR order may not be clinically or ethically sound. This is a reflection of the dismal outcomes from CPR in this population. Perhaps obligatory CPR, which is a common occurrence in emergency rooms, acute medical wards and intensive care units, is not beneficial in a defined group of frail, elderly, chronically ill, long-term care patients. CPR is usually performed when such patients are discovered without vital signs. Their extremely poor survival – even under the best of circumstances – might be due to the fact that they lack the biological reserve to withstand CPR, or because the cardiac event is the final common pathway for death from their multiple co-morbidities. If this were the case, perhaps the halakhic principle that would otherwise support CPR in people with a true unanticipated cardiac arrest might benefit from a review by halakhic scholars. In view of the well-documented bleak clinical outcomes in this frail, long-term care elderly population, we suggest that its use be reconsidered.

CPR in the frail elderly

To understand the potential benefit of CPR in the frail elderly, especially those who live permanently in long-term care facilities (primarily nursing homes), a review of the relevant literature is necessary. In this population, CPR has been shown to offer little if anything in terms of survival [12-18]. Even under the conditions where on-site arrest teams are available, the outcomes from CPR are at best grim.

Most long-term care facilities do not have 24 hour full CPR capability and depend on emergency response services and rapid transfer to an ER for further emergency care. This results in substantial delay for patients whose clinically determined likelihood of survival is minuscule. A 1990 study demonstrated that when resuscitation was performed on residents who had suffered a cardiac arrest in a nursing home, only 2 of 117 patients (1.7%) survived to hospital discharge [18]. One of those survivors spent 30 days in the hospital and died 8 months after returning to the nursing home – demented, cachectic, and with a large sacral pressure sore. In another review there were no survivors, using 100 days post-arrest as the outcome measure, out of more than 100 cases of CPR.

ER = emergency room

There were in fact very few immediate survivors even in settings of 24 hour on-site full CPR capability – conditions that do not exist in the vast majority of long-term care facilities in most countries including Israel [12]. A 1997 study reported that there were no survivors when CPR was applied to 182 elderly nursing home residents out of a total of 2348 out-of-hospital cardiac arrests [17].

With this evidence from the medical literature, why is it still the norm to provide CPR as the *modus exitus* for this very frail elderly population? It seems that both the secular and halakhic justification for CPR reflects the idea of saving a life (*pikuah nefesh*), which is a powerful treatment motivation. The contemporary secular and religious model of “salvage” is based on populations for whom CPR offers some chance of survival. In geriatric long-term care patients, such a beneficial outcome is generally not the case. The usual criteria for admission to permanent long-term care facilities reflect the multiple complex medical problems and frailty that lead to the poor outcomes from attempted CPR in this population [12]. In many long-term care facilities, attempts are made to obtain DNR orders in order to avoid CPR. However, for many reasons DNR orders may be unobtainable, or some people for personal or religious reasons may be opposed to a DNR order. This may be the case for observant Jews for whom the agreement to sacrifice even a moment of life may conflict with their deeply felt commitment to the sanctity of life. When a DNR order has not been obtained, certain necessary protocols and policies must be implemented to avoid inappropriate CPR. Such a policy should be based on the practice of initiating CPR *only* when the arrest is witnessed and unexpected – two minimal criteria for the remote likelihood of a successful outcome. This would seem to be a reasonable administrative method of handling this scenario. The vast majority of people in long-term care are “found” dead rather than in the throes of dying, or with a true cardiac arrest. The initiation of CPR would therefore be unlikely if these two criteria were used as the basis for implementing CPR.

Attempting on-site CPR even when the staffing capability exists, or sending these long-term care residents via ambulance to an ER seems to be inappropriate in terms of clinical outcome, ethical principles and humanitarian considerations. The transfer is usually from a facility that knows the patient and family and can make judgments to forgo CPR to an ER where the staff would feel obligated to carry out what will likely be ineffectual CPR. Families should be told by physicians and other healthcare providers about the limited benefits to be gained from CPR [13]. The staff should inform them that even in the absence of a DNR order, CPR might not be attempted except in very limited and well-defined circumstances.

The concept of *gosses* and CPR

An important tenet of Judaism is the respect for a *gosses* [19,20]. A *gosses* refers to an ancient Talmudic concept. A person is designated a *gosses* when he or she is in the throes of dying and therefore should be treated in a way that respects and does not impede the dying process. In modern terms, it is a way of trying to define an immediate foreseeable trajectory of dying, formally and historically one to three days or less (the classical definition of a *gosses*). This prognostic ability often exists even in an era of

modern medical technology and is usually based on the clinical situation and the known and expected outcomes of any possible clinical interventions. It is difficult to determine from the literature how many long-term patients who underwent CPR have survived more than the three days traditionally used when describing the *gosses* status. In most patients who die after CPR the death occurs within the first few hours or days, sometimes after failed attempts to maintain them on life-support systems.

The very humane principle of respecting the dying process helps religious and secular individuals understand the importance of the concept of the *gosses*. With the known poor outcomes, it suggests that perhaps in the contemporary context, providing CPR to Jewish frail, long-term care elderly individuals who experience a cardiac arrest is an affront to the concept of the *gosses*. If this is so, what might be done for this well-defined population is to treat cardiac arrest as a stage in imminent dying. Therefore, instead of attempting ineffectual CPR, which is clearly undignified and intrusive to the dying process, it would be preferable to treat the person as a *gosses* and allow him or her to die peacefully with no impediments to that process.

Some scholars suggest that CPR should be provided to this population because some elderly patients do survive. However, in the geriatric long-term care population such survival has been shown repeatedly to be extremely rare [12-18]. In view of the long history that promotes CPR, despite its poor results, it may be worth reconsidering the CPR-dying-*gosses* equation specifically concerning the very frail geriatric long-term care population. Perhaps the halakhic principles that govern how such clinical situations are approached should be examined in the face of the evidence on lack of survival.

It might be of theoretical value to review each case by halakhic scholars (*poskim*), so that individuals at risk of receiving ineffectual CPR might trigger a timely DNR discussion. The likelihood of most long-term care facilities with frail elderly Jewish residents being able to mobilize sufficient numbers of halakhic advisors to address the needs of each potential CPR candidate makes such an approach unrealistic. Rather, halakhic scholars interested in the subject should confer with the clinical experts to determine whether the contemporary interpretation of the implications of the status of a *gosses* and its relationship to CPR merits further examination.

Physicians involved in the care of the frail Jewish elderly often struggle in their quest to provide optimal clinical as well as religiously and culturally respectful care. This is especially the case when physicians are also dealing with observant families who are acting as surrogates and whose views and values may or may not accurately or completely reflect those of the patient they represent. A careful review and critical analysis of the evidence and outcomes in CPR in this population might result in sending fewer frail and chronically ill long-term patients to emergency rooms for ineffectual CPR. If this were the case, we would allow such frail individuals to die peacefully within the framework meant for a *gosses* in the long-term care facility that was in fact their home.

Conclusions

Physicians and halakhic scholars should revisit the CPR issue as it pertains to the chronically ill frail elderly who reside in long-term

care facilities. If the position proposed in this paper is acceptable, it could change the way the very frail elderly Jewish long-term care residents are approached during the final period of their lives. Rather than considering the dying event as a potentially reversible medical emergency and thereby exposing frail elders to CPR – an undignified and physically intrusive and likely painful last few moments of life – it could be transformed to one of an uninterrupted, peaceful and halakhically sound transition from life to death.

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