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Ethical and Clinical Issues in Cardiopulmonary Resuscitation (CPR) in the Frail Elderly with Dementia: A Jewish Perspective

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ABSTRACT

Few clinical situations arouse more emotion and drama and lead to more conflict in decision-making than cardio-pulmonary resuscitation (CPR). The procedure was described as potentially beneficial more than 40 years ago. However, its efficacy and place in the care of the frail elderly have taken a long time to be established. In the world of secular medical practice, there are many situations when CPR may be provided to elderly, frail and cognitively compromised individuals for whom its clinical benefit is questionable. In those patients suffering from dementia, surrogates are responsible for decision-making, which complicates the process. When the clinical uncertainty is coupled with strong cultural and religious influences, as within Orthodox Judaism, the development of an acceptable approach to cardiac arrest is more challenging. A clinically sound, ethically defensible and religiously sensitive approach to CPR requires a deep understanding of all the factors involved in the decision-making process and may require periodic re-evaluation not only by clinicians but by religious scholars and leaders.

Dementia is one of the main factors that require families to choose a long-term care environment for their loved one. The frail elderly suffering from dementia are a group of individuals for whom institutional long-term care may become necessary. As a group they face many special clinical needs, which may pose unique challenges in emergency situations. The ethical challenges, especially in the realm of end-of-life decisions or potentially life-ending events such as cardiac arrest are of special interest (Conroy, 2006; Gordon, 1995, 2001; Gordon & Singer, 1995). During the past 30 years, in much of the Western world, and certainly in North America, a good deal of ethical deliberation has been based on secular values, as described by Beauchamps and Childress (2001) in their development of Principlism. This framework is used in many clinical scenarios (Adams, 2004). However, in many Western nations, there is an increasing number of citizens with strong ethnic and religious beliefs, which may provide a counter-balance to traditional or secular values and discourse as a basis of ethical decision-making in complex clinical situations.

For those elders with special ethnic or religious views or beliefs, health care professionals should try and understand the meaning of these values in the decision-making process, especially when issues of life and death are in question. In those societies that have a multicultural and varied religious make-up of their populations, the situation becomes complicated because of the impact on decision-making that religious views may engender among family members, patients and health care professionals (Markwell, 2001; Daar & Khitany, 2001; Goldsand, 2001).

Health Care Decisions and *Halacha*

For the Jewish elderly whether abroad or in Israel, health care decision issues, especially those at the end of life may be affected by *Halachic* interpretations depending on the degree of orthodoxy of the patient and the involved family (Jakobovits, 1995; Weingarten, 2002; Freedman, 1999; Steinberg, 1994; Novak, 1990; Friedman, 1993; Grodin, 1995). *Halacha* is Jewish Law. As it pertains to the practice of medicine it has a long history of development, interpretation and re-interpretation. For Jews, even those who are not Orthodox, it often has a substantial 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, *Halachic* interpretations and advice from scholars and rabbis responsible for interpreting Jewish Law may be of great importance when difficult clinical decisions, as when life and death hang in the balance, are being contemplated. There are often situations where the values, local laws and decision-making options of individuals conflict with *Halacha* and may result in tensions and controversies in treatment. Institutional policies may result in potential conflicts depending on how secular or religious-based the policy appears to be and how it affects individuals across the spectrum of Jewish religious belief.

In medical emergencies, there is usually an overriding obligation to save the life potentially at risk. This is congruent with most secular principles as well as with the *Halachic* value of *pecuach nefish* (saving of a life because all life is sacred). Cardiopulmonary resuscitation (CPR) is an example: The normal clinical obligation in response to a cardiac arrest is generally to initiate immediate CPR. This is done with the hope that by restoring the heart and lung function it may be possible to prevent what otherwise

would be imminent death and reverse the underlying condition that caused the cardiac arrest in the first place. Currently, in most Western countries, unless there is a specific refusal to have CPR performed through a "Do Not Resuscitate" (DNR) order, physicians and nurses are obligated to undertake CPR until success or failure occurs.

During the past few years, the data related to CPR in the elderly frail population, who live in long-term care facilities in which a large percentage suffer from dementia at various levels of severity, suggests that perhaps the standard paradigm of CPR, unless refused through a DNR order, may not be clinically and ethically applicable. This is related to the dismal outcomes that have been found in this population. Perhaps the obligatory application of CPR, which is a common occurrence in the emergency room (ER), is not potentially beneficial in a defined group of frail elderly long-term care patients that suffer from many concurrent illnesses including end stage dementia that compromise their ability to survive CPR. This might be so, not because they have no intrinsic "human value", but because they do not have the biological reserve to withstand CPR or because the cardiac event is really the final common pathway for death from their multiple co-morbidities. If this is the case, perhaps the *Halachic* principle, which would support CPR in anyone with a cardiac arrest, might benefit from a review by *Halachic* scholars and rabbis of its applicability in the face of the circumstances and well-documented dismal clinical outcomes that surround this frail, elderly long-term care population.

Outcomes of Cardiopulmonary Resuscitation (CPR) in the Frail Elderly

In order to understand the potential place and benefit of CPR in the frail elderly that live permanently, often because of severe dementia among other chronic illnesses, in long-term care facilities (nursing homes and chronic care hospitals or units) a review of the relevant literature is necessary. In this population, CPR has been shown to offer little if anything in terms of survival (Gordon,1995; Gordon, 2001; Zweig, 1998; Stein, 1996; Ditillo, 1996; Benkendorf, 1997; Zweig, 1997). Even under the conditions where arrest "teams" are readily available, which is rare and limited to a very few large academic facilities that may have on-site medical interns and residents immediately available, the outcomes from CPR are at best grim. Most long-term care facilities do not have 24-hour round-the-clock full CPR capability. Rather, they depend on emergency response services and rapid transfer to an ER for further emergency care, which results in substantial delay in full CPR to patients whose clinically determined likelihood of survival is minuscule.

A 1990 study demonstrated that when resuscitation was performed on residents who had suffered cardiac arrest in a nursing home, only two of 117 (1.7%) patients survived to hospital discharge (Applebaum, 1990). One of those survivors spent 30 days in the hospital and died eight months after returning to the nursing home demented, cachectic and with a large sacral pressure sore. In a review by Gordon (1995), in more than 100 cases there were no survivors of CPR using 100 days post-arrest as the outcome measure. There were in fact very few immediate survivors and these studies reflected settings where there was 24-hour on-site maximum resuscitative capability, a situation that does not exist in the vast majority of long-term care facilities in most countries. In a 1997 study, it was 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 (Benkdendorf, 1997). More recent studies substantiate previous observations (Conroy, 2006; Fidler, 2006).

With this evidence from the medical literature, why is it still often the norm to provide CPR as the modus exitus to this very frail elderly population? It seems that both the secular and Halachic justification for CPR reflects the idea of saving a life (pecuach nefesh), which is a powerful treatment motivation. But, the contemporary secular and religious model of "salvage" is actually based on populations for whom CPR offers some semblance for survival. But, in geriatric long-term care patients, such a beneficial outcome is far less likely than for younger patients or the many relatively healthy elderly population that do not require long-term care because of the complexity of their medical and cognitive status. The need and usual criteria for admission for permanent long-term care is a good marker for multiple complex physical and cognitive problems and frailty and the dismal outcomes from attempted CPR (Gordon, 1995).

In many long-term care facilities, attempts are made to obtain do-not–resuscitate (DNR) orders in order to avoid the implementation of CPR, which is unlikely to confer any clinical benefit. However, for many reasons, DNR orders may not have been obtained or some people for personal or religious reasons may be opposed to the provision of a DNR order. This may be the case for observant Jews for whom the agreement to sacrifice even a moment of life may be in conflict with their Halachic commitment to the sanctity of life. When a DNR order has not been obtained, certain necessary protocols and policies must be implemented in order to avoid inappropriate CPR. There are two minimal criteria which should be in place before CPR is initiated: that the event is witnessed; and that it is unexpected. A CPR policy that spells out these criteria in detail would be a reasonable administrative approach to those who do not have a DNR order in place (Gordon, 2003). 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 of implementing CPR.

Attempting on-site CPR even when the capability, staff-wise, exists or sending such patients via ambulance to an ER seems to be an inappropriate transfer of clinical and ethical responsibility. The transfer is from those who know the patient and family and can make such judgements to forgo CPR to an ER staff that would feel obligated to carry out what will in all likelihood be ineffectual CPR. Families should be told by physicians and other health care providers about the limited benefits to be gained from CPR (Gordon, 2001, 2003). They should be informed that even in the absence of a DNR order, CPR might not be attempted other than in very limited and well-defined and circumscribed circumstances.

Within Judaism, the Concept of Goses and CPR

An important tenet of Judaism which should be considered in a deliberation of the CPR process is the respect for a Goses (Shema Yisrael; Eisenberg, 1999). A Goses refers to the ancient Talmudic criteria by which a person who is in the throes of dying is identified and treated in a way that respects the state of events and the inevitability of immediately foreseeable death and does nothing to interfere with the dying process. In modern terms, it is a way of trying to define the trajectory of dying as one might in a terminal patient undergoing palliative care. In ancient times, when the concept of the Goses was developed, it was defined as one to three days or less. This prognostic ability often exists even in an era of modern medical technology and should be based on the clinical situation and the known and expected outcomes of any possible clinical interventions. It is hard to determine from literature, how many of these patients in long-term care who receive CPR survive and how many of the few immediate responders may have survived more than the traditional three days that is usually used when describing the Goses status. Most patients who die, do so within the first few moments, hours or days, often experiencing failed attempts at CPR or efforts to maintain them on life-support systems.

The important concept of allowing a person to die, for whom there is virtually no chance for living and respecting the process so that it is dignified and uninterrupted, is difficult to resist within a secular framework. The concept of the Goses appears to be the Halachic basis for such a respectful approach as well. Its conceptual framework was described in the tenth century by Rabbi Moshe Isserles and as noted by Washofsky (2005) prohibits " …anything which constitutes a hindrance to the departure of the soul such as chattering noise or salt upon his tongue [attempting to revive him]…since such acts involve no active hastening of death, but only the removal of the impediment".

This very humane principle helps form the foundational understanding of the Goses. It suggests that perhaps attempting CPR on Jewish, elderly, frail, long-term care individuals, many of whom suffer from dementia and who have experienced a "cardiac arrest", and for whom the likelihood of immediate or even short-term survival is virtually non-existent, is an affront to the concept of the Goses. If this is so, it may be that what should be done for this well-defined population is to treat "cardiac arrests" as a stage in imminent dying. Therefore, instead of attempting ineffectual CPR, which is clearly undignified and intrusive to the dying process, treat the person as a Goses and allow them to die peaceably with no impediments to that process.

It would not be surprising to hear some Halachic scholars suggest that even in the face of those overwhelming odds, CPR should be provided to this population in any event because some elderly patients do survive. To deny the opportunity for those lives to be saved would be in conflict with the over-riding Halachic duty to save lives. The question becomes, just how likely is CPR to be of benefit in this population and whether the rare occasional success merits the more frequent occurrence of violating the concept of the dying process as exemplified in the concept of the Goses. In the geriatric long-term care population survival from "cardiac arrests" is extremely rare (Gordon, 1995; Gordon, 2001; Zweig, 1998; Stein, 1996; Ditillo, 2002; Benkendorf, 1997; Zweig, 1997). In view of the long history that promotes CPR, despite its poor results, it may be worth re-considering the CPR-dying-Goses paradigm specifically when it comes to the very frail geriatric long-term care population. Perhaps the Halachic principles that govern how such clinical situations are approached should be re-examined in the face of the evidence about lack of survival. Ideally, it might be of value for each case to be reviewed by Halachic scholars (poseks) so that individuals at risk of receiving ineffectual CPR might implement a timely DNR discussion and order. However, the likelihood of most long-term care facilities that have frail, chronically ill elderly Jewish residents, being able to mobilize the number of Halachic scholars to address the needs of all the potential CPR candidates on a one-to-one basis, would make such an approach unrealistic. Rather, Halachic scholars, interested in the field should confer with the clinical experts to determine if the contemporary interpretation of the implications of the status of a Goses and its relationship to likely ineffectual attempts at CPR can be further examined. If so, perhaps the emphasis should be changed to forgo CPR and to allow death to occur without interventions that would be in conflict with the concept of the Goses.

In some ways, what is being proposed to Halachic scholars is to frame the situation as one might when an individual is deemed suitable for the late stages of palliative care, where terminal symptom management is the focus of treatment. In such situations, it would be a rare occurrence that those responsible for care would consider CPR as an option if the patient appeared to succumb to the illness for which palliative care was being provided, even if it were prior to the anticipated time of death. It is not saying that elderly individuals requiring long-term care are necessarily comparable to those in a palliative care program. Many have long periods of potentially satisfying and fruitful lives ahead of them and deserve full and respectful care. But, because of their underlying medical frailty, a "cardiac arrest" is tantamount to the very terminal stage of an individual receiving palliative care and should not be treated by CPR.

It is a challenge to physicians involved in the care of the frail Jewish elderly to provide optimal clinical and religiously and culturally respectful care. Similar challenges occur in other religious and ethnocultural groups whose elderly frail members reside in long-term care facilities. When physicians are dealing with families who are acting as surrogates, because of the cognitive impairment or dementia of their family members, it might be apparent that the family's views may or may not accurately or completely reflect those of the patient they represent. For those of the Jewish faith who are observant and struggling to follow Halacha while at the same time wishing to avoid unnecessary dramatic interventions and suffering, the struggle between the saving of a life and the respect for a Goses can be most disquieting. A careful reconsideration of the evidence and outcomes of CPR in this population might result in fewer frail, chronically ill long-term patients being sent to the ER via an ambulance for ineffectual CPR because they have suffered a life-ending cardiac arrest. Rather, they would be allowed to die peacefully and in a dignified fashion and within the framework meant for a Goses, in the place that was their home.

Conclusion

Physicians and Halachic scholars should revisit the discussion of the relationship and obligation to save a life and the obligation to respect the Goses. If the position that is proposed is acceptable to rabbis and Halachic scholars, it could change the way the very frail elderly, Jewish long-term care residents are approached during the last period of their lives. In place of considering the dying event in a "medically emergent" manner, and exposing frail elders to an undignified and physically intrusive and, at times, apparently painful last few moments of life, it could revert to one of an uninterrupted, peaceful and Halachacally sound transition from life to death.

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