Dear Dr. Jeff:

Our state laws allow physicians to forgo cardiopulmonary resuscitation on the grounds of “medical futility.” We are often urged to write notes or sign orders based on this criterion, but I don’t know of any accepted definition. What do you suggest?

Dr. Jeff responds: The role of medicine is “to cure sometimes, treat often, and comfort always.” All ill patients have incurable diseases, albeit not untreatable ones. And certainly all can be comforted. Cardiopulmonary resuscitation for frail seniors is indisputably not comforting. But is it futile?

National rates of successful resuscitation after cardiopulmonary arrest are quite low, regardless of patient, practitioner, and location—below 8% for out-of-hospital arrests and 15% for those occurring in the hospital. Moreover, definitions of “success” vary, as some would consider the transient restoration of sufficient pulse and blood pressure to allow hospital transfer a success, even if the patient expires in the emergency room. Others would only consider resuscitation successful if the patient survived 30 days, or was ultimately able to maintain spontaneous respiration off a ventilator. Still others might require the patient return to functional neurologic status as a minimum requirement to define CPR as successful. Even in medical centers with access to emergency angioplasties, no one claims high success rates by stringent criteria.

The data for cardiac arrest in the nursing home is relatively sparse, with a German and a Canadian series both showing no survivors at 30 days, although a few patients did have return of spontaneous pulse sufficient for transport to a hospital. A 2007 article in the Journal of the American Medical Directors Association reported a 2% success rate (Shah, MN et al. J Am Med Dir Assoc 2007;8(Suppl 2):e27–e31). This 2% represented a single individual who was alive 1 year later. The presence of advanced age, frailty, and multiple medical comorbidities lowers success rates in any setting. Recovery from a witnessed arrest is more likely than for the resident found pulseless and apneic on rounds. Recovery rates when an automated external defibrillator is available may be higher, particularly as survival prospects are greatest for patients with underlying cardiac rhythms of ventricular tachycardia or ventricular fibrillation and lowest for those with electromechanical dissociation or no electrical activity (flatline). Monitored patients in cardiac care units probably have the greatest chance of resuscitation as their dysrhythmias can be immediately identified and addressed, whereas survival after simple chest compression is much less likely.

Evolution of Nursing Home CPR

At one time, many nursing homes had policies stating that CPR was not available in the facility. These policies were based on the extraordinarily low success rates, lack of on-site medical personnel or trained nursing staff, and a desire to respect the bodies of the dead. They often were included as part of the admissions agreement. They were, in my experience, invariably acceptable to families and residents. However, the Centers for Medicare & Medicaid Services specifically stated in a series of revisions to the State Operations Manual: Appendix PP—Guidance to Surveyors for Long Term Care Facilities that a facility-wide “no CPR” policy is forbidden. CMS acknowledges that “research generally shows that CPR is ineffective in the elderly nursing home population,” but has concluded a facility-wide policy violates a resident’s right to form an advance directive. Indeed, facilities are required to have trained staff available at all times to initiate CPR when a resident has not explicitly refused it.

In 2016, more than 15% of nursing home residents are younger than 65 years old. Moreover, the rapid growth of PA programs has brought a significant number of comparatively young and vigorous patients into the world of skilled nursing facilities, patients who do not see themselves as “residents” and fully expect to return to the community with improved physical function. Thus, a person-centered approach would mandate offering such residents a procedure that might afford them a significant, albeit small, chance at prolonged survival.

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Defining Success

If all can agree that conditions under which there is absolutely no prospect of achieving an effect defines futility, whereas an extremely low but not trivial success rate (such as 2% quoted earlier) does not, there may be an intermediate range in which “medical futility” could still be recognized. Some have suggested that a success rate of less than 1% should define futility (Schneiderman RL, et al. Ann Intern Med 1990;112:949–51). This seems rather arbitrary. Less than 0.1% or less than 0.01% also are possible standards. Even if we get to a one-in-a-million chance, this might still be a valid choice for some patients.

Interventions that cannot possibly improve a patient’s condition are also futile, or to use the more polite term, “medically ineffective.” For example, an instruction to “do everything” for a resident could include hemodialysis, but there is no reason that a resident dying from a massive stroke with normal kidneys would benefit from such a procedure. Interventions, even those that have physiological effects, are not mandatory if the effect would not advance the goals of care. Similarly, interventions that are outside the purview of medical care are not mandatory for the medical practitioner. Many believe in the power of prayer, but there is no ethical requirement for a physician to pray with the patient or family.

Physicians are obligated to avoid actions that are likely to injure a patient, or those they consider ineffective. If a practitioner truly believes that CPR would be ineffective, as when a patient is overwhelmed by their disease, the obligation is both to explain this to the patient and family and to withhold the procedure.

Definition dictionaries of futility tend to offer both the notion of “without effect” and “without purpose.” These are actually somewhat different notions. If CPR produced a few extra days of life spent in an intensive care unit, it was not without effect. It might, however, be seen as without purpose since the patient died anyway. Purpose relates to the goals of care, and these goals are defined by the patient and family along with the treatment team. There might be circumstances when those extra days allowed family to gather at the bedside and say their goodbyes. There are also many situations in which the extra days simply prolonged the suffering of the dying or increased family stress or generated burdensome medical costs. For the overwhelming majority of unsuccessful attempted resuscitations, the resident is already dead and the negative outcome is only the distress for facility staff and the injuries sustained by the corpse.

Declarations of medical futility shouldn’t be substituted for meaningful discussions with residents and families regarding a resident’s medical status, prognosis, and goals of care. A simple reading of a resident’s list of medical problems and diagnoses leaves many families shocked. Hospitalists tend to focus on the immediate presenting problem (that’s their job) rather than the trajectory of the disease or the multiple comorbidities. Care plan teams in the nursing home rarely feel competent to discuss diagnosis and prognosis with the resident or family, expecting that the medical practitioners will. Reassurances that the resident is stable or the hospital care plan will be continued may be the total message delivered.

When a family asks that “everything be done” they might have a picture of the risks and benefits of various interventions in the context of their loved one. They may be repeating a wish expressed by their family member. More often, they are influenced by the 75% success rate estimated for CPR on television shows combined with a heartfelt desire that all reasonable medical care will be provided. No one wants their family member ignored or neglected. Often, after a discussion of the actual medical situation and of the possibility to do everything to make a resident as comfortable as possible, the actual goals of care are clearer. But if a resident or family wants an attempt at CPR and the attempt would not be physiologically without effect, their wishes should be respected.

We are healers, not gatekeepers. Sometimes, there is comfort for a family knowing the resident’s wishes were honored, even when “doing everything” was unsuccessful. Comfort is never futile.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board. Read this and other columns at www.caringforteages.com under “Columns.”