

We Need to Talk

By Helen Hinchliff

(As published in the Driftwood on 6 May 2015)

“Call a code!” his daughter shouted when Donald started convulsing. Immediately, medical staff came running.

It was about one in the afternoon on July 15, 1999, and we were waiting for the ambulance that would bring my late husband Donald back to Lady Minto from Victoria General Hospital. He'd been sent there for a CT scan to determine whether the stroke he'd experienced at 7:30 that morning had been ischemic (usually caused by a clot cutting blood flow to the brain) or hemorrhagic (usually caused by a burst aneurism flooding blood into the brain). Every minute counts when someone is having a stroke, but a correct diagnosis must be made. Ischemic and hemorrhagic strokes require diametrically opposed treatments.

Donald was wheeled down to Emergency while still convulsing. Suddenly, he couldn't breathe, almost certainly because he had aspirated saliva. Emergency personnel induced a coma, intubated and suctioned him, and transferred him to Intensive Care. He didn't wake up for days.

The ICU doctor showed me the CT scan revealing a large, black area on the left side where much of his brain had died due to blocked blood flow. He asked whether we might

wish to pull the plug, but family members were coming from a remote and distant location and I wanted to wait.

Donald awoke nine days later, and the doctor delivered the news: “He has the worst possible outcome. The right side of his body is completely paralyzed. He will be able to understand everything, but he will be unable to say anything.”

That prognosis was tough to accept, so we rejected it. Three weeks later at the Vic General neurology ward, the neurologist announced, “Your husband is not a candidate for further rehabilitation and you will be unable to care for him at home. We are discharging him tomorrow into long-term care.”

Very quickly, I came to grips with reality and inquired whether Lady Minto might have a long-term care bed; otherwise, he would have been assigned to the first bed available anywhere in greater Victoria or Saanich.

A few weeks ago, I learned that some 25 businesses and organizations on Salt Spring Island have installed automated external defibrillators. Everyone’s hoping to save lives and many will have heard about the young man in Vancouver who collapsed recently in a 10K race and was revived with compressions and an AED.

But has anyone considered what can happen to seniors undergoing similar treatment? I’ve been asking people what they know about the use of AEDs. Almost no one has understood that when a person suddenly collapses, brain

and organ damage due to loss of blood circulation are likely unless chest compressions are immediately administered at the rate of 100 per minute and at a depth of 2 inches (5 centimeters) per compression. This is done for two minutes before administering defibrillation (“[Why Proper Chest Compressions are so Important](#), from [www.aedchallenge.com](#) and “[Update on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Guidelines](#),” from [www.medscape.com](#)).

Dr. David Davis, a family practitioner at Christian Hospital in St. Louis who has had 35 years’ experience as an emergency room physician, says CPR is “violent.” If you do it hard enough to induce circulation, “you’re going to break ribs and maybe the sternum” of frail seniors. He commented, “If older people and their families knew what was involved, the manipulation, the tubes, the drugs, and the low chances for a good outcome, they’d opt for comfort care instead.” (Paula Span, “More on CPR for the Elderly,” <http://newoldage.blogs.nytimes.2012/08/10>.)

Span also describes in her “How Successful is CPR in Older Patients?” piece Oakland County, Michigan, kept track of outcomes for some 2,600 out-of-hospital cardiac arrests over a four-and-one-half year period. She points to a study that found fewer than 10 percent were resuscitated and the older the patient, the less chance there was of success: 8.1 percent of patients in their 60s, 7.1 percent in their 70s, and 3.3 percent in their 80s survived to the point of discharge from acute care.

Statistics weren't available about what happened next, but it's my guess that many seniors would find themselves discharged directly into long term care—resulting either from brain damage caused by inadequate CPR or from more CPR than their frail bones could handle.

It's also my guess that those favouring purchases of AEDs aren't thinking about how their own life might be saved; instead, they're likely imagining they'll be saving somebody else's life.

If we are the people whose lives they hope to save, I suggest we start thinking and talking about whether we want to experience two minutes worth of deep and rapid compressions. Once we've made up our minds, we need to let others know our wishes before somebody else starts calling codes and our outcome turns out to be ending our days in a nursing home.