



Joint Cancer Experiences Collaborative and PCRS Conference
End of Life Decision Making: dilemmas and directions

Speaker, Oral and Poster
Abstracts

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Speaker Presentations

Overview of key issues

Simon Chapman

This presentation will set the scene for the study day and in particular will consider:

- what is meant by “end of life”
- different types of end of life decision, both clinical and non-clinical
- the context in which decisions are made
- personal and relational autonomy
- who decision-makers are
- the factors involved in decision-making
- medical and non-medical dilemmas.

A view from clinical practice

Simon Conroy

The aim of this talk is to provide a brief overview of common end of life decision issues in clinical practice. Firstly, cardiopulmonary resuscitation will be discussed in terms of the ethical decision making framework, the benefits and burdens and the role of autonomy. Secondly, autonomy will be discussed in terms of the ability to take decisions, including assessing capacity. Finally, methods to enhance decision making capacity will be covered – namely, advance care planning.

Several real life clinical scenarios will be presented to highlight the clinical dilemmas faced.

Frequency of medical end of life decisions and euthanasia practices in The Netherlands and Belgium

Professor Luc Deliens

Worldwide, there is little data about the frequency of end-of-life decisions made involving doctors and terminally ill patients, except for Belgium and The Netherlands. Medical decision-making for patients with life-threatening diseases entails a balanced consideration of medical, ethical, psychosocial, and societal aspects. These considerations and the legal background in a country could modify end-of-life decision-making practices and attitudes of doctors, patients and other people involved. Medical end-of-life decisions include: whether to withhold or withdraw potentially life-prolonging treatment—e.g., mechanical ventilation, tube-feeding, and dialysis; whether to alleviate pain or other symptoms with, for example, opioids, benzodiazepines, or barbiturates in doses large enough to hasten death as a possible or certain side effect; and whether

to consider euthanasia or doctor-assisted suicide, which can be defined as the administration, prescription, or supply of drugs to end life at the patient's explicit request.

In Belgium and The Netherlands around a third of deaths happen suddenly or unexpectedly and do not therefore involve end-of-life decisions. Such decisions are common among the remaining two-thirds of deaths: end-of-life decisions occur in about 40% of all deaths in both countries. Estimates on administration of drugs with the explicit intention of hastening death at the explicit request of the patient (euthanasia) varies between 0.3 % and 2.6% (over time). Large variations between both countries are recorded in the extent to which end-of-life decisions are discussed with patients, relatives, and other caregivers. In both countries extended empirical research has been developed over the last 10 years and in both countries the law making on euthanasia do not conflict, but seems to reinforce palliative care developments.

Studying end of life decisions in the UK

Clive Seale

Considerable knowledge about the prevalence of different end-of-life decisions across a number of countries has been generated by surveys using questionnaires and methods developed in pioneering studies done in the 1990s in The Netherlands. In some countries this knowledge has influenced public opinion and legislators. The experience of carrying out a survey of end-of-life decisions involving UK doctors will be used to reflect on (a) the public reception and mass media reporting of such studies and (b) methodological issues associated with such work, which use questions constructed within one medical culture that are perhaps not easily transferred to another. Other approaches to generating useful knowledge about end-of-life decisions will be considered.

Oral Presentations

Factors that contribute to physicians' treatment decisions when patients have advanced cancer

Carole Willard, Kalbir Kaur-Mann

School of Nursing, Midwifery & Social Work, University of Manchester

Background

Improvements in treatment mean that many cancer patients live for several years with advancing disease. Current health care policy advocates that treatment decisions should be based on the best available evidence and patients' preferences. It appears however, that treatment decision making in advanced cancer is challenging for health professionals and that despite the emphasis on teamwork, physicians are the most

important players in relation to treatment decision making. Recent research reveals that in the acute care environment, professional-patient consultations and interventions are driven by a preoccupation with treatment - even when patients are unlikely to benefit - and negative perceptions of palliative care. These factors shape treatment decisions and may prevent patients from making informed choices about their future care and treatment.

Aims - The study was funded by Cancer Research UK. The aims were to:

1. Identify the factors physicians take into account when making decisions about withholding, withdrawing, continuing or initiating treatment when patients have advanced cancer
2. Explore physicians' beliefs and goals when making treatment decisions in advanced cancer
3. Investigate the process of treatment decision making.

Participants - Twelve senior oncology physicians caring for patients with lung, colorectal, ovarian, upper gastro-intestinal and haematological cancers.

Data collection - A grounded theory approach informed this qualitative study. Data were collected in one tertiary cancer centre using non-participant observation and recorded interviews.

Analysis - Observation field notes and transcribed interviews were analysed using the constant comparative method to identify over-arching concepts.

Findings - A number of triggers for treatment decision making were found. The main goal and concern of participants was 'staving off the inevitable' for patients with advanced cancer. This concern was managed by a complex, staged and treatment-dominated process 'looking for treatment options'. This presentation will focus on the main aspects of this process and their implications.

Advanced care planning in dementia: challenges and opportunities

Riitta Kukkastenvemas, Ingela Thune-Boyle, Michael King, Martin Blanchard

Department of Mental Health Sciences, UCL Medical School, London

Louise Jones, Elisabeth Sampson

Marie Curie Palliative Care Research Unit, UCL Medical School, London

Introduction - End of life care decision making in dementia is complicated by problems in predicting disease progression and lack of capacity of the person affected. Families are often expected to make difficult decisions yet they are rarely informed of likely outcomes. The aim of this study was to design and pilot an intervention to enhance decision making and improve care.

Methodology - Using the MRC framework for complex interventions, this randomised phase II intervention study consisted of a palliative care needs assessment and advance care planning (ACP) to enhance relatives' understanding of end stage dementia, support their decision making, reduce unplanned emergency hospital admissions and improve satisfaction with care. Participants were identified during acute general hospital admission; the research was predominantly carried out after discharge.

Results - Thirty-three percent of those with advanced dementia admitted to the acute general hospital did not have an available next of kin, indicating an added complication to their care. The families available were reluctant to participate in research during hospital admission, thus the protocol was modified to allow the research to be carried out after discharge. Overall, relatives found the intervention useful; ACP has been completed by 26%. Those who made an ACP were closely involved in their relative's care and had witnessed symptoms such as pain and feeding difficulties as well as communication problems. Reasons for non-completion included complicated family dynamics and reluctance to address end of life issues. The intervention appears timely as 40% of patients with advanced dementia died within 6 months from the hospital admission.

Conclusions - Families appear to be more receptive to engaging in ACP discussions if they have experienced worsening of their relative's symptoms related to dementia. Admission to the acute general hospital may offer a timely opportunity to involve the families in the end of life care decision making.

The fundamental impact of recognising dying on decision-making

Sabine Pleschberger, Claudia Wenzel, Alexandra Hornek

Department of Palliative Care & Organisational Ethics, University of Klagenfurt

Background/Aim - One problem in end of life care, which is largely unresolved is the fact that dying is often not recognised as such, and when it is, it is often not acknowledged. To improve quality in end-of-life care, and even more so, to make dying at home possible it is essential that the professionals recognize dying and that all involved acknowledge it somehow and get support according to their needs. The aim of this paper is to show how recognising and acknowledging dying influences decision-making in end-of-life care.

Methods - We refer to data of an ongoing ethnographic study, in which participant observation in a palliative home care service is done to get a deeper understanding of the processes taking place during the transition into the dying phase. The sample consists of up to 20 cases. Observations include visits of the palliative care team in the patient's homes from first contact until the patient's death. Interviews with family members and involved professionals are in each case supplement the data.

Results – Recognising, and even more so, acknowledging dying, is no simple diagnosis but a complex social process in which the dynamics of a number of people, first and foremost the patient and his or her family, must be taken in account. Decision-making about hospital admissions often stress the fact of different views about the stage of progression. Health professionals play a central role in supporting acknowledgment and/or accepting denial within the families and act as facilitators in decision-making processes.

Conclusion -For decision making in end-of-life care at home, it is crucial to recognise dying and acknowledgment is a fundamental issue. Health professionals not only need training in communication skills but also need support by professionals or lay persons, to advocate the process of acknowledgment as this goes beyond medical interventions.

Poster Presentations

Poster 1

Ethics and the diagnosis of dying

Peter Allmark, Angela Tod

Centre for Health and Social Care Research, Sheffield Hallam University

Mark Cobb, Jane Liddle

Sheffield Teaching Hospitals

The use of a diagnosis of dying in UK end-of-life care is well established. The purpose of this poster is to show that difficult ethical and legal judgement is involved in a diagnosis of dying. The poster uses scenarios in which doctors make decisions that appear to shorten patients` lives following a diagnosis of dying. The professional guidelines talk of these decisions being, say, the withdrawal of non-essential or the commencement of essential treatment. However, there is ethical judgement behind the use of such terms as "essential" as well as complex legal issues. A famous dictum from Devlin J [1957] states: "If the acts done intended to kill and did, in fact, kill, it did not matter if a life were cut short by weeks or months, it was just as much murder as if it were cut short by years."

This appears to move us into the area of the doctrine of double effect and the distinction between intention and foreseeing. However, it is highly controversial. In this poster our cases show how the doctrine provides intuitively plausible support for the ethical and legal judgements made with a diagnosis of dying. We show also, though, that such judgements are subject to strong objections. The poster ends with research questions. We intend to provide forms on which people can provide their thoughts on the issues plus their contact details should they wish to be kept in touch with the progress of our project.

Poster 2

Advance care planning in advanced cancer – can it be achieved?

Cate Barlow, Jane Harrington, Louise Jones

Marie Curie Palliative Care Research Unit, UCL, London

Michael King

Department of Mental Health Sciences, UCL, London

Patients facing life threatening illnesses may wish to talk to a trained professional about the future and make decisions about their care. Enabling a discussion of advance care planning might facilitate for patients an increase in openness with their families and healthcare professionals. A patient preference randomised controlled exploratory trial was conducted to assess the feasibility and acceptability of offering patients such discussions. We aimed to identify the problems in carrying out this research and to highlight solutions adopted. Participants were recruited from oncology out patient clinics in a London NHS trust.

It was difficult to recruit patients as quickly as anticipated although a target of 90 patients was achieved. There were two main problems:

- 'Gate-keeping' by clinicians due to the sensitive nature of the study
- Clinicians reporting being 'too busy' to approach patients

Regular attendances in the daily clinics by the research team helped to reinforce the importance of study. A protocol amendment, approved by ethics, allowed the research team to approach patients directly once they had been identified as eligible by the clinician and this helped to increase recruitment. Approximately 30% of patients approached agreed to participate, follow up rates were in excess of 80% and only one patient withdrew. Over time, clinicians became aware that patients were not becoming distressed and this lowered concerns about the sensitive nature of the research. There is some evidence in the literature that claims of being 'too busy' in this context may be masking underlying reasons for reluctance to introduce a difficult subject with patients or a new healthcare intervention. Such ideas need further exploration. End of life care discussions are recommended in the recent DH end of life care strategy and issues raised by this study must be addressed before implementation of this policy could be achieved.

Poster 3

Evaluation of the decisions at Life's End (DALE) Project

Kay Phelps

University of Leicester

The decisions at Life's end (DALE) project is a two year pilot funded by the Department of Health: Partnership for Older People Projects (POPP) Programme. The aim of the DALE project is to give more people over 60 the choice to die at home if this is appropriate and is their wish.

This formative evaluation of the DALE project is intended to work with the project team to provide information on service implementation as it happens, to inform further service development. The evaluation consists of several streams of work:

1. Focus groups with older people and their carers to identify needs and wishes for end of life care and explore experiences and expectations.
2. Focus groups with health professionals in the community who provide end of life care to explore views and experiences of services available and changes and developments which would improve choice and care.
3. Collection of data on service users of the DALE project to identify service use and characteristics of service users.
4. Analysis of death certificate data over 3 years to identify changes and trends in place of death and assess DALE impact.
5. Analysis of acute hospital deaths of people over 60 who have had no invasive intervention in the last 7 days of life to identify changes and trends and assess DALE impact.
6. Case studies of people who have used the DALE service consisting of interviews with relatives and health professionals involved. To identify best practice and problems in care to further inform service development.

Though the DALE project has been running for only 18 months there is already a body of evidence to suggest that the service is having an impact. Deaths in acute hospitals have been reduced and quality of care for people dying at home has been improved.

Poster 4

Discharging Dad from hospital to home – a daughter's story

Helen Carter

Oxford, UK

This paper intends to contribute to organisational learning and decision making by clinical staff in hospital and community settings. It is a reflective account written by a daughter who was also a PCT senior manager. The key aspects of the paper refer to the author's experience of the last few weeks of the life of her father. The paper maps the journey of

decision making that contributed to, and also worked in opposition to, facilitating a fast discharge from hospital to home.

The key areas that are highlighted are:

- The end of life care criteria assessment and communication of information across organisations
- Discharge planning and availability of services in the community
- How information is communicated to families
- A father's journey to death
- The challenges of being a daughter and health care professional

This presentation is a moving experience of a family who managed to discharge their father from hospital to home "despite the NHS and social services." It is presented to audiences to enable consideration of the key issues that organisations need to look at including planning someone's death with them in advance of any final admission to hospital, facilitating faster discharge, and communicating effectively with individuals and across organisations.

The author uses her experience as a senior manager to question the sole reliance upon the complaints system to feedback something that is not actually a complaint and the need for a mechanism that had less negative connotations.

The main intention for this reflective article is to contribute positively to the end of life care agenda in that it urges PCTs and end of life care providers to actively seek the perspective as relatives to ensure that services are developed in appropriate ways for the benefit of the patient and their carers.

Poster 5

Autonomy and decision-making at the end of life: older peoples perspectives

Eileen Sutton

Department of Social Medicine, University of Bristol

Joanna Coast

Department of Health Economics, University of Birmingham

The United Kingdom end of life care strategy, published in June 2008, recommends the identification, documentation and review of people's preferences for care and, like much government policy highlights the importance of choice at an individual level.

This poster reports findings from a qualitative interview study with 23 people over the age of 65, conducted in order to discover their preferences for care at the end of life. Older people's thoughts on decision-making processes are explored, with a specific focus on the factors impacting upon decisions around preferences for life-sustaining treatment. Implications for theories of autonomous decision-making are also examined in relation to care at the end of life.

Various factors including quality of life and dignity, self-perceived burden, gender and religious beliefs impact upon older people's decision-making processes, particularly those concerning preferences for life-sustaining measures. Decision-making processes are complex, as older people consider not only themselves, but also the impact on their loved ones and even wider society, and often defer decisions until absolutely necessary. Whilst having a say is important to the older people, those with family encourage their involvement in decision-making, pointing to a relational conception of autonomy in this context. Nevertheless, older people's choices may be constrained due to a lack of availability of unpaid care, which may lead them to leave their homes and go to live in residential care, despite wishing to remain at home until they die. They may also be disadvantaged in terms of service provision such as specialist palliative care, which may place limits on their choices. A deficit of information and awareness of the practicalities and legal implications of advance decisions also needs to be addressed to aid older people's decision-making processes.

Poster 6

Making decisions about care; what it means for hospice in-patients with terminal, progressive disease

Simon Fisher

Audit, Pilgrims Hospices, Ashford

Hazel Colyer

Health & Social Care, Canterbury Christ Church University

There is very little research into patients who suffer from a terminal and progressive illness making decisions about health care in a hospice setting. What decision making means to the inpatients in a hospice ward could be better understood by staff caring for this patient group.

This piece of qualitative research seeks to address what it means to patients to make decisions by engaging in interviews with six patients who have experienced inpatient care in a hospice. A phenomenological approach was taken using Van Manen's (1990) theoretical framework to explore their life world and its existential meaning.

The decisions that came to the fore for the participants were around the driving force behind admission, which was often pain. Beyond this, often traumatic, event they were able to be robust in decision making about day to day issues. Other decisions related to the purpose of the admission such as symptom control, achieving independence, whether to have further treatment, communication with their families and returning to the community. The whole meaning of the data was patients' increased awareness of the fragility of their existence, which was brought into focus by the decision to be admitted to the hospice.

This has implications for hospice care in the home to replace the need to be admitted where possible and provide support to patients and families to achieve this. There are also indications in this research that the hospice inpatient environment is welcome but has the potential to be disempowering for the more robust patients.

Poster 7

Researching attitudes to end of life decisions among physically disabled people

Margo Milne

Faculty of Health and Social Care, Open University, Milton Keynes

The issues of assisted suicide and other end-of-life decisions as they affect disabled people remain high on the political agenda, with increased attention on high-profile cases in the media. While polls have compared the opinions of “disabled people” as a whole on end-of-life decisions with those of the general population, limited work has been done on the diversity within this group. Furthermore, organisations such as Dignity in Dying and Not Dead Yet present their cases as if all disabled people have one unified opinion on end-of-life decisions. However this may not be the case, and there may be differences depending on, for instance, whether the individual’s disability is congenital or acquired, or whether it is stable or progressive. Other demographic factors such as age, sex and ethnicity may also be important.

This poster will present the basis for the methodology for my PhD research into disability and end-of-life issues. I am using both qualitative focus groups and a quantitative questionnaire, each using different groups of participants. My aim is to triangulate both by method and by participants in order to gain breadth and depth of insight into the topic. The focus groups will be analysed using thematic analysis, which allows themes in data to be identified, analysed and reported in rich detail, but with minimal organisation. The questionnaire data will be analysed using an appropriate statistical package. Qualitative and quantitative data will be linked in analysis to produce an overall theoretical framework.

Both the focus groups and the questionnaire use vignettes to obtain attitudes towards end-of-life decisions. This allows attitudes to end-of-life decisions to be explored within a real-life setting, while nevertheless distancing decision-making emotionally from participants’ own lives. It therefore minimises any personal distress from what is clearly a potentially upsetting topic.

Poster 8

The Planning, Implementing and Evaluation of the Training in Issues Arising from the MCA (2005)

Brenda Ward

St Giles Hospice, Lichfield, Birmingham

Louise Stone

John Taylor Hospice, Erdington, Birmingham

Diana Webb

Pan Birmingham Palliative Care Network, Birmingham

Background - The MCA has a profound effect on decision making in palliative care. Recognising its importance, a Working Party at John Taylor Hospice was set up.

Aim - To ensure everyone in the organisation is aware of the MCA and its implications for their work. To develop and implement a workable system to ensure the MCA is adhered to.

Method - Achieved through raising awareness, education and enhancement of documentation.

Awareness - Creation and display of posters throughout the hospice and relevant reading material distributed.

Training - Internal system of workshops aimed at all clinical staff arranged. Each workshop comprised of:

- A presentation
- Guided group palliative care case discussions with feedback
- A test in the form of a questionnaire. Participants were given relevant scenarios with 4-5 statements, which required a true or false answer
- Evaluation forms.

Documentation - A MCA pro-forma developed and placed in notes of all hospice patients to ensure that information about patients' and carers' wishes / choices had been sought, clearly recorded and updated as necessary. Documentation for those lacking capacity was adapted from existent material.

Results - 5 MCA training workshops for 43 staff members. 5 members failed to reach the required mark in the questionnaire and received additional individual training. Feedback via the evaluation forms was extremely positive. The hospice now has a register of all staff having taken the training, including the date and test score. Follow up via questionnaire after approx 8 months showed staff were reasonably confident in their understanding of the MCA in spite of little experience in some aspects. They believed the assessment of capacity and best interests had improved and most felt the work carried out by MCA working party had been useful.

Conclusions - The process was successful in providing training, evidence of training, and evidence of the effectiveness of the training.

Poster 9

What processes are at work in a patient-carer dyad when discussing end of life issues?

Philomena M Swarbrick
Lancaster University

Aims - To gain in-depth understanding of the approach to end of life advance care planning by those diagnosed with terminal illness and to observe the interactions between these patients and their close carers when decision-making is being discussed.

Objectives - To hear the voice of a patient who is both fully informed and

aware of the diagnosis of life-limiting illness, together with the closest carer. To encourage the disclosure of concerns and hopes that occur during the future-gazing required when approaching decisions about end of life care for the patient.

Methods - This study comprised a single in-depth, semi-structured interview within the dyad of a terminally ill man and his wife. The resulting transcript was analysed using interpretative phenomenological analysis to gain a thorough understanding of the text, both in terms of attitudes, values and beliefs of the two participants and in terms of the interactions noted to be taking place within the dyad. Findings: The major themes emerging from this study are those of; the desire to maintain normality of life; the internal conflict arising when planning ahead threatens to allow the illness to become the overwhelming focus of living; methods used to controlling the nature and volume of received information; permissible information distribution within the dyad; the impact of religious faith on decision-making; the impact of previous experiences on decision-making and the description of 'self' as an indicator for advance care planning approaches.

Conclusions - Patients and their carers have embedded ideas about the nature of the 'selves' that they desire to present to the outside world and this impacts on how they wish to approach the end of life and influences how advance care planning might be carried out, with or without healthcare professionals. Despite this, ideas and thoughts about end of life issues continue to evolve as discussions proceed.

Poster 10

How do hospice staff decide when to start the Liverpool care pathway for the dying patient

R Latten, M Gambles, JE Ellershaw

Marie Curie Palliative Care Institute Liverpool

EMI Williams

Division of Public Health, University of Liverpool

Aim - To improve understanding of hospice staff decision making when recognising the last days of life and commencing the Liverpool Care Pathway for the dying patient (LCP).

Background - Appropriate use of the LCP relies on healthcare staff recognising the transition to the dying phase. One of the main determinants for LCP commencement is that: "The multi-professional team has agreed that the patient is dying" along with assessment of patient mobility, conscious level and oral intake. However these physical factors can also apply to situations other than dying which may be potentially reversible. This reinforces the importance of the teams' ability to discriminate between potentially treatable, reversible situations and the dying phase.

Method - An ethnographic qualitative study, designed to examine how hospice staff make these decisions and the information used to make them, performed in 3 stages:

1. Retrospective content analysis of case-notes, examining staff documentation of the last days of life.
2. A prospective period of staff observation during multi-disciplinary team and ward handover meetings.
3. Semi-structured interviews with hospice staff.

Results - Staff documentation of the last 7 days of life was examined in 25 sets of case-notes. Over a 6 week period, just over 13 hours of clinical meetings were observed, involving a range of staff disciplines. Interviews are currently progressing. Results to date suggest staff use a range of information when deciding if a patient has entered the dying phase. Physical findings including changes in skin tone, conscious level, mobility, oral intake and breathing pattern were considered. Non-physical factors such as patient statements, psychological state and staff instinct were also influential.

Conclusion - Diagnosing the dying phase is an important, but often challenging, skill for hospice staff. Ongoing interviews will provide further insight into the process. Future study expansion to additional units is also planned.

Poster 11

The views of bereaved relatives about their involvement with end of life decision making

CR Mayland, EMI Williams, J Addington-Hall, JE Ellershaw

Aim - To compare bereaved relatives' views in hospice and hospital settings about their involvement with end-of-life decision-making.

Method - Evaluating Care & Health Outcomes-for the Dying (ECHO-D) is a 94 item postal self-completion questionnaire developed to assess bereaved relatives' views about the quality of care for dying patients and their families. The next-of-kin to 778 patients who had died from cancer in a hospice or hospital during a 21 month period were identified and asked to complete ECHO-D.

Results - Following exclusions (n = 53), 255 (35.2%) next-of-kin agreed to participate. Fifty-six (51.4%) hospice participants reported they were 'very involved' with decisions compared with 48 (32.9%) hospital participants (p=0.007).

Thirty-three (30.3%) hospice participants and 26 (17.8%) hospital participants reported that their next-of-kin had discussed their preferred place of care with the healthcare team (p=0.04). A greater proportion of hospice participants thought their next-of-kin had died in the 'right place' (hospice 89.9%, hospital 56.8%, p<0.0001).

Discussions about the appropriateness of giving intravenous fluids occurred with similar frequency in both settings (hospice 26.6%, hospital 26.0%). Of those who hadn't had these type of discussions, 66 (45.2%) hospital participants indicated that a discussion would have been useful compared with 20 (18.3%) hospice participants (p<0.0001).

Hospice participants perceived the healthcare team more frequently discussed what would happen at the time of death compared with hospital participants (hospice 40.4%, hospital 22.6%, $p=0.002$). Of those who hadn't had these types of discussion, 67 (45.9%) hospital participants would have found these discussions useful compared with 26 (23.9%) hospice participants ($p=0.03$).

Conclusions - Hospice participants were most involved in end-of-life decision-making and had the fewest unmet information needs. Within this group of bereaved relatives, more open discussion about pertinent issues e.g. use of intravenous fluids and what to expect when someone is dying would have been useful in both healthcare settings.

Poster 12

Resuscitation and end of life care in A&E

Stephen Brummell, Jane Seymour

Sue Ryder Centre in Palliative Care, The University of Nottingham

Gina Higginbottam

Faculty of Nursing, The University of Alberta, Canada

Despite technological advances in cardiopulmonary resuscitation, unsuccessful resuscitation in accident and emergency departments is common. The transition from active resuscitation to end of life care and preparing the dead body is therefore frequently encountered and must occur rapidly. Staff involved in caring for cardiac arrest patients must evolve strategies for dealing with the complex ethical dilemmas that this creates. This workshop aims to illuminate the ethical dilemmas surrounding resuscitation and the shift from patient-care to body-care, drawing on the findings from a doctoral study which explores these practices. These practices often remain concealed and unknown outside of A&E.

The first dilemma; whether to continue pre-hospital resuscitation? This was influenced by how staff categorised cardiac arrest patients to enable them to differentiate resuscitation situations. These categories were constructed using a combination of bodily and technical data, which were influenced by the social circumstances and context of each individual event. The second dilemma: how long to continue resuscitation? Determining the point at which resuscitation was withdrawn required the alignment of technical and bodily data, enabling staff to accept a patients' death. Central concepts such as "downtime" and "elderly", which underpinned decision making, were constructed over time and were dependant on the practitioner's experiential exposure to cardiac arrest events. These became more and more refined and consistent through clinical contact. The third dilemma: when does the "patient" become a "body" following the withdrawal of resuscitation?

The practices of preparing the body and laying-out were highly significant and the creation of an acceptable image of death may also act to recompense for the potentially "violent" interventions of resuscitation. The formal last-offices procedure involved wrapping the patient in a sheet, removing the patient's shape and form. These formed a crucial component for staff in facilitating the transition from "patient", to that of "dead body".