

# CPR Attitudes: Understanding Resuscitation Preferences

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## Introduction to Attitudes toward Resuscitation

Attitudes toward resuscitation represent a complex nexus of medical, ethical, psychological, and sociological considerations surrounding the decision to initiate or withhold life-sustaining interventions, particularly cardiopulmonary resuscitation (CPR). These attitudes are not monolithic; they vary significantly across patient populations, healthcare providers, family members, and cultural groups, profoundly influencing end-of-life care planning and clinical decision-making. Understanding these diverse perspectives is crucial for promoting patient-centered care, ensuring respect for **autonomy**, and minimizing moral distress among caregivers. The core of this discussion revolves around the perception of benefit versus burden associated with interventions like CPR, mechanical ventilation, and advanced cardiac life support (ACLS), especially when faced with serious chronic illness or terminal diagnoses. Furthermore, societal views, often shaped by media portrayals of resuscitation success, frequently diverge sharply from the grim statistical realities of outcomes in vulnerable populations, necessitating careful educational efforts to align expectations with clinical likelihoods.

The concept of a "Do Not Resuscitate" (DNR) order, or its more comprehensive contemporary equivalent, "Allow Natural Death" (AND), formalizes these attitudes within the medical record, serving as a directive to the medical team. However, the efficacy of these directives hinges on the clarity of communication and the depth of understanding held by all parties involved. A patient's attitude toward resuscitation is often rooted in their fundamental values regarding quality of life, fear of death, religious beliefs, and perceived dignity. For many, the prospect of surviving a cardiac arrest only to face severe neurological impairment or protracted dependence on life support is viewed as a greater harm than death itself. This value judgment underscores why standardized protocols must always yield to individualized care plans based on thorough discussions of prognosis and potential post-resuscitation functional status.

The psychological mechanisms underlying these attitudes are manifold, involving cognitive biases such as **optimism bias**--the tendency to believe that risks are lower for oneself than for others--and framing effects, where the presentation of information significantly alters the choice made. For instance, emphasizing the small chance of a good outcome may elicit a different response than emphasizing the high probability of a poor outcome, even when the underlying statistics are identical. Therefore, effective communication requires not only factual accuracy but also sensitivity to how information is processed by individuals under emotional duress. The evolving field of palliative medicine strives to integrate these psychological insights into clinical practice, ensuring that discussions about resuscitation are timely, comprehensive, and conducted in an environment that fosters genuine understanding rather than coercion or passive compliance.

## Historical and Ethical Context of CPR and DNR Orders

The modern practice of resuscitation emerged in the mid-20th century, primarily driven by the development of closed-chest cardiac massage and mechanical ventilation techniques. Initially conceived as an intervention for unexpected cardiac arrests in otherwise healthy individuals, its application quickly expanded, leading to profound ethical dilemmas concerning its use in patients with advanced, irreversible diseases. This expansion necessitated the formalization of mechanisms to limit unwanted interventions, giving rise to the Do Not Resuscitate (DNR) order. Historically, the implementation of DNR orders was often inconsistent, sometimes decided unilaterally by physicians, which subsequently led to legal and ethical mandates emphasizing patient involvement and informed consent as paramount requirements for restricting life-saving care. The evolution reflects a shift from paternalistic medical authority toward a model centered on **patient rights** and self-determination.

Ethically, the decision regarding resuscitation engages several core principles of biomedical ethics. Foremost among these is autonomy, the patient's right to self-govern their medical treatment, including the right to refuse potentially life-prolonging measures. This principle mandates that attitudes toward resuscitation, whether affirmative or negative, must be respected, provided the patient possesses decision-making capacity. Equally important are the principles of **beneficence** (acting in the patient's best interest) and **non-maleficence** (avoiding harm). When resuscitation offers little chance of meaningful survival or guarantees a high probability of severe suffering, the ethical duty shifts from performing the intervention to withholding it, recognizing that CPR, in certain clinical contexts, constitutes a non-beneficial and potentially harmful procedure.

The concept of medical futility further complicates attitudes toward resuscitation. While physicians generally agree that interventions that have no physiological chance of success should be withheld, defining futility remains contentious, often relying on probabilistic assessments rather than absolute certainty. Attitudes diverge sharply when discussing quantitative futility (where success rates are exceedingly low, perhaps less than 1%) versus qualitative futility (where the outcome, though technically successful, is deemed unacceptable by the patient or society, such as survival in a persistent vegetative state). Open dialogue is required to bridge the gap between a physician's professional assessment of medical efficacy and a patient's personal valuation of life quality, ensuring that the final decision aligns with the patient's definition of a life worth living.

Furthermore, the moral status of withholding versus withdrawing life support is often debated, influencing both patient and provider attitudes. While ethically and legally they are generally considered equivalent, psychologically, withdrawing an ongoing treatment (like extubation) is often perceived as more difficult than withholding a treatment not yet started (like CPR). This psychological resistance can influence the timing and nature of resuscitation discussions, sometimes leading to the initiation of full code status simply because the opportunity for a

discussion was missed earlier in the illness trajectory. Addressing this psychological burden requires systematic training for healthcare providers in proactive **end-of-life communication** and palliative care principles.

## Patient Autonomy and Informed Consent in Resuscitation Decisions

Respect for patient autonomy demands that attitudes toward resuscitation are formed through a process of robust **informed consent** or informed refusal. This process requires the medical team to disclose not only the procedure itself but also the specific risks, benefits, and realistic outcomes tailored to the individual patient's underlying health status and prognosis. Simply asking a patient, "Do you want us to do everything?" is inadequate and often leads to decisions based on incomplete or idealized information. A truly informed attitude requires understanding the likelihood of survival to discharge, the probability of severe neurological deficit, and the potential for rib fractures, pneumothorax, and other serious complications inherent to resuscitation attempts, particularly in the elderly or frail population.

Decision-making capacity is a fundamental prerequisite for exercising autonomy in resuscitation choices. Capacity assessment must be dynamic and sensitive to fluctuating clinical states, ensuring that the patient understands the information, appreciates the consequences of their choice, manipulates the relevant data logically, and expresses a consistent preference. When capacity is compromised, the responsibility shifts to designated surrogate decision-makers. However, the patient's previously expressed attitudes, often captured in advance directives or Physician Orders for Life-Sustaining Treatment (POLST) forms, must guide the surrogate's decisions, ensuring the principle of **substituted judgment** is upheld, rather than relying solely on the surrogate's personal preferences or emotional distress.

Advance care planning (ACP) serves as the primary mechanism for translating patient attitudes into actionable medical orders. ACP involves a structured conversation about future healthcare wishes, values, and goals, ideally occurring long before a crisis renders the patient incapable of participation. Studies consistently show that patients who engage in ACP are more likely to have their end-of-life wishes respected, experience less aggressive and more palliative care, and report higher satisfaction with their care. Nevertheless, societal attitudes often view these discussions as morbid or premature, leading to low completion rates of advance directives, thus frustrating the exercise of autonomy when critical decisions must be made urgently.

The challenge of translating abstract attitudes into concrete medical preferences is substantial. Patients often express a desire for "quality of life," but defining this threshold requires deep exploration. For some, quality of life might preclude any degree of dependence; for others, merely being conscious and free of severe pain is sufficient. Clinicians must skillfully explore these nuanced definitions, using narrative medicine techniques to understand the patient's life story and

the values that drive their choices regarding life prolongation. Only through this detailed exploration can the medical team ensure that the patient's attitude toward resuscitation genuinely reflects their deeply held goals and values, rather than a fleeting response to fear or pressure.

## Factors Influencing Patient Attitudes

A multitude of interconnected factors influence a patient's attitude toward resuscitation, ranging from demographic variables to specific illness characteristics. Age is a significant predictor; generally, older patients and those with multiple comorbidities are more likely to opt for DNR status, recognizing the diminishing returns and increased risks associated with CPR in their context. Conversely, younger patients, particularly those facing acute but potentially reversible conditions, often maintain a strong preference for full resuscitative efforts, reflecting a greater investment in future life years and a higher baseline expectation of recovery. However, these are broad generalizations, and individual preferences often defy statistical averages, emphasizing the need for **personalized assessment**.

The patient's prognosis and perceived quality of life are perhaps the most influential determinants. Patients who understand that their underlying disease--such as metastatic cancer, end-stage heart failure, or severe chronic obstructive pulmonary disease--makes survival from cardiac arrest highly unlikely or guarantees a poor functional outcome are significantly more inclined to choose comfort measures. Furthermore, patients' personal experience with death and dying, whether through witnessing the suffering of loved ones or observing the often-violent nature of resuscitation attempts, powerfully shapes their attitudes. Negative personal experiences tend to shift preferences toward non-intervention, prioritizing a **peaceful death** over potential prolongation of suffering.

Cultural, religious, and spiritual beliefs exert profound influence on attitudes toward resuscitation. Many faith traditions provide specific guidance regarding the sanctity of life, the acceptance of death, and the permissibility of withholding medical interventions. For example, some traditions view life-sustaining treatment as obligatory until the very moment of natural death, while others prioritize avoiding excessive suffering or view death as a natural transition that should not be unduly postponed by aggressive medical technology. Clinicians must demonstrate **cultural humility**, actively inquiring about these spiritual preferences rather than making assumptions, ensuring that the resuscitation plan is congruent with the patient's deepest metaphysical commitments.

Finally, the patient's level of health literacy and the manner in which information is communicated critically mediate their attitudes. Patients who lack a clear understanding of the difference between CPR and other life-sustaining treatments (like antibiotics or dialysis) may express inappropriate preferences. Moreover, the emotional tone and framing utilized by the healthcare provider--

whether emphasizing hope for recovery or focusing on the harsh realities of failure--can dramatically sway the patient's decision. Effective communication involves using clear, non-technical language, utilizing visual aids when appropriate, and repeating complex information to ensure comprehension, thereby enabling the patient to form a rational and informed attitude regarding their end-of-life care.

## Healthcare Provider Attitudes and Bias

Healthcare providers' attitudes toward resuscitation are complex and often influenced by professional training, personal values, institutional culture, and experience with poor outcomes. Physicians and nurses who frequently witness the low success rates and high morbidity associated with CPR in critically ill populations tend to adopt a more cautious and selective approach, often advocating for comfort measures when the prognosis is grim. Conversely, trainees or those working in acute, critical care settings might harbor more optimistic views, sometimes driven by the professional obligation to 'save life' or by the emotional difficulty of passively accepting death, which can inadvertently lead to overly aggressive treatment recommendations.

A significant challenge is the presence of **implicit bias** among providers, which can unconsciously influence the quality and depth of resuscitation discussions offered to different patient groups. Studies have indicated that providers may be less likely to initiate frank, proactive discussions about DNR orders with younger patients, minority groups, or those perceived as having higher social worth, potentially violating the principle of equity in care. Furthermore, providers sometimes struggle with **moral distress** when they feel compelled by family pressure or institutional policy to perform CPR that they deem futile, leading to burnout and dissatisfaction. Addressing these biases requires mandatory ethics training and robust institutional policies that support clinicians in refusing to perform medically inappropriate interventions.

The professional culture of medicine often prioritizes intervention over non-intervention, creating an environment where providers may feel professionally obligated to offer maximal treatment even when they privately believe it is not in the patient's best interest. This conflict between the perceived duty to act and the ethical duty to avoid harm contributes significantly to variations in provider attitudes. Effective palliative care integration aims to reframe the professional duty, emphasizing that excellent end-of-life care involves careful discernment, skilled communication, and the relief of suffering, rather than the relentless pursuit of biological life at all costs. This cultural shift requires strong leadership and systematic support for **shared decision-making** models.

Furthermore, providers' personal experiences with death and their own mortality beliefs inevitably shape their clinical recommendations. A provider who has personally chosen a DNR status for a loved one may approach the discussion with greater empathy and realism than a provider who

views death primarily as a medical failure to be avoided. Recognizing and managing these personal attitudes is crucial for maintaining objectivity. Tools like structured communication protocols (e.g., the SPIKES or NURSE frameworks) are essential for ensuring that personal bias does not overshadow the ethical requirement to present information fairly and comprehensively, allowing the patient's autonomous preference to prevail.

## Family and Surrogate Decision-Maker Perspectives

When patients lack decision-making capacity, their attitudes toward resuscitation must be interpreted and acted upon by family members or legally appointed surrogates. This transition introduces complex emotional and relational dynamics that significantly impact the final decision. Family attitudes are often driven by grief, guilt, hope, or unresolved relationship issues with the patient, making objective decision-making extremely difficult. Surrogates may struggle to reconcile their own intense desire for the patient's survival with the patient's known preferences, leading to decisions that maximize intervention even when the patient had clearly expressed a wish for comfort care.

The concept of **substituted judgment** ethically requires the surrogate to make the decision the patient would have made if capable. However, studies show that surrogates are often poor predictors of the patient's actual preferences, particularly if the patient did not engage in explicit advance care planning. When the patient's wishes are unknown, the standard shifts to the "best interest" standard, which requires the surrogate and medical team to determine the most reasonable course of action based on objective medical information and what a reasonable person would choose under the circumstances. These situations often lead to conflict, as different family members may hold widely divergent attitudes regarding the patient's quality of life and the appropriateness of aggressive intervention.

Communication with families requires exceptional sensitivity and skill. Clinicians must navigate family dynamics, manage unrealistic expectations fueled by misinformed hope or media portrayals, and provide emotional support while simultaneously delivering difficult prognostic news. Effective communication involves framing the discussion around the patient's goals of care, shifting the focus from "whether to stop fighting" to "how best to care for the patient now." When family attitudes clash with the medical team's assessment of futility, robust institutional **ethics consultations** are often necessary to mediate disagreements and ensure that care remains ethically sound and patient-centered, even in the absence of the patient's voice.

Furthermore, the burden placed on surrogates who must decide whether to withhold resuscitation is immense, often leading to long-term psychological distress, known as "surrogate grief." Recognizing this, healthcare systems must provide adequate support, ensuring surrogates understand that choosing comfort care is not abandoning the patient but rather choosing a

dignified and peaceful path aligned with established palliative principles. Proactive, repeated conversations that normalize death and emphasize the positive aspects of focusing on symptom management can help shape family attitudes toward acceptance and reduce the moral injury associated with these critical decisions.

## Legal and Policy Frameworks Governing Resuscitation Decisions

Legal frameworks across jurisdictions establish the parameters within which attitudes toward resuscitation are operationalized and protected. The fundamental legal principle is that competent adults have the right to refuse any medical treatment, including CPR, even if the refusal may lead to death. Legal instruments such as **advance directives** (living wills and durable powers of attorney for healthcare) provide legal authority for patients' preferences, ensuring that their attitudes are honored even after they lose capacity. The development of standardized, transportable orders like POLST (Physician Orders for Life-Sustaining Treatment) has significantly improved the portability and enforceability of resuscitation preferences across different care settings.

However, legal ambiguity often arises in cases of medical futility. While some states grant physicians the legal right to unilaterally withhold resuscitation when it is deemed medically futile, other jurisdictions require mediation or ethics review before overriding the patient's or family's request for full code status. These variations reflect a societal tension between respecting patient autonomy (the right to demand treatment) and protecting physician integrity (the right to refuse to provide non-beneficial care). Policies must strive to balance these competing interests, typically by establishing clear institutional processes for conflict resolution that involve multidisciplinary review and adequate transparency.

Institutional policies play a critical role in shaping provider attitudes and ensuring consistency. Hospitals and long-term care facilities must have explicit, accessible policies regarding the initiation, documentation, and review of DNR orders. Policies must address specific scenarios, such as unexpected arrests outside of designated critical care areas or the temporary suspension of DNR orders for elective procedures. Inconsistencies in policy or documentation can lead to ethical breaches, such as a patient intended to be DNR receiving full resuscitation because the order was not clearly communicated or transferred upon admission, thus violating the patient's established attitude toward intervention.

The legal landscape is also shaped by evolving definitions of brain death and the legal status of withdrawal of life support. Litigation often arises when families challenge the validity of advance directives, dispute the patient's capacity at the time the decision was made, or disagree with the medical determination of futility. These high-profile legal battles underscore the necessity of clear, well-documented communication and the proactive involvement of legal and ethics experts in

complex cases. Compliance with these frameworks ensures that the execution of resuscitation orders is legally defensible and ethically sound, reflecting a deep respect for the patient's fundamental right to self-determination.

## Communication Strategies for End-of-Life Planning

Effective communication is the single most critical factor in accurately discerning and implementing patient attitudes toward resuscitation. It requires moving beyond simple checklists and engaging in sophisticated, goal-oriented discussions. The ideal approach involves proactive, layered conversations that begin early in the course of a serious illness, long before the patient is in extremis. Clinicians should use open-ended questions to explore the patient's understanding of their illness, their priorities, and their fears, thereby uncovering the values that underpin their resuscitation preferences. This approach ensures that the decision is context-specific and aligned with the patient's overall philosophy of life and death.

Key communication strategies involve the use of prognostic information delivered with honesty and compassion. Instead of focusing solely on the procedure of CPR, providers should frame the discussion around the trajectory of the patient's illness and the statistical probability of surviving **with an acceptable quality of life**. Using phrases like, "Given your heart condition, if your heart stopped, the chance of leaving the hospital and living for another month is less than 5%, and many who survive face severe brain damage," provides realistic context that encourages informed refusal when appropriate. Avoiding medical jargon and replacing euphemisms with clear, direct language about death and dying is essential for minimizing confusion and ensuring true informed consent.

A structured approach, such as the use of the "Ask-Tell-Ask" method, helps manage the flow of difficult information. First, **ask** the patient what they understand about their current health status and what they hope for the future. Second, **tell** the patient the relevant medical facts and realistic prognosis clearly. Third, **ask** the patient how this new information influences their goals of care and their attitude toward resuscitation. This iterative process ensures that the discussion is collaborative and that the patient feels heard and respected, mitigating feelings of abandonment often associated with discussions about limiting life support.

Finally, documentation of resuscitation attitudes must be precise and reflective of the nuanced conversation that occurred. Documentation should detail not only the final decision (e.g., DNR/Full Code) but also the evidence that the patient had decision-making capacity, the specific risks and benefits discussed, and the patient's expressed reasons for their choice. High-quality documentation serves as a critical bridge between the patient's attitude and the actions of the medical team, providing a legally and ethically sound record that guides care across transitions and ensures continuity of the patient's wishes, thereby honoring their autonomy to the very end.