



## EDITOR'S CHOICE

# We need to talk about resuscitation

Rebecca Coombes *head of news and views*

The BMJ

Doctors are often reluctant to start conversations about resuscitation decisions. In four articles *The BMJ* squares up to decisions on “Do not attempt cardiopulmonary resuscitation” (DNACPR), to spark debate about an area of clinical practice often fraught with legal and ethical challenges.

Zoe Fritz and colleagues describe how doctors are hesitant to raise DNACPR in case it distresses patients or leads to a complaint (doi:10.1136/bmj.j813; doi:10.1136/bmj.j876). But patients rarely start this conversation either, even though research shows that many older people are perfectly willing to talk about the limits of treatment.

DNACPR notices first appeared in the 1970s to prevent cardiopulmonary resuscitation that people didn't want or that wouldn't work. They have protected many people from harm. But when isolated from other treatment decisions they have become a problem for patients and clinicians. Inconsistencies in decision making, communication, and documentation have led to misunderstandings, write Fritz and colleagues. Consequences range from futile and inappropriate resuscitation attempts to inappropriate withholding of treatments.

Kate Masters testifies to these consequences (doi:10.1136/bmj.j1084). When her mother, Janet Tracey, who had terminal cancer, broke her neck in a car crash, a DNACPR notice was

drawn up without any discussion. The case led to a judgment in 2014 that gave clinicians a duty to consult patients. Masters' conversations with doctors show that some feel burdened by this new duty. They say, “Why should we discuss something that won't work?” “We can't get hold of the relatives,” “It always happens in the middle of the night.”

A way out of this impasse is to shift the focus from the specific decision about resuscitation to plans that focus on broader emergency care preferences, of which it is but a part. The approach highlighted in *The BMJ* (doi:10.1136/bmj.j813; doi:10.1136/bmj.j876) is an emergency care plan that focuses on broader goals such as “do all you can to keep me alive and well” or “don't try to keep me going if I'd lose my independence.” The approach can be begun in different care settings, including on admission to hospital or at an outpatient clinic for a patient with a life limiting condition.

David Oliver is open to this new approach (doi:10.1136/bmj.j1143). His attitude has softened over the years, from “dying people need protection from undignified, distressing medicalised intervention” to “we should do all we can to avoid CPR without patient consent.”

No one underestimates the difficulties in realising such plans. It will take valuable time, but let's start the conversation.