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ACUTE PERSPECTIVE

David Oliver: Detoxifying DNACPR decisions

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Could healthcare practitioners do more to demystify and detoxify the public conversation on “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPR) decisions? Even before covid-19, DNACPR orders featured in many a misunderstanding or formal complaint. The pandemic response has made these orders more contentious, and the Care Quality Commission recently announced that it would review how DNACPR decisions had been used during the pandemic.¹

Stories had emerged earlier in the pandemic of NHS commissioners pressuring local care homes to complete DNACPR orders for residents en masse² or GP surgeries writing to registered patients with serious illnesses, asking them to complete forms.³ Doctors and advocacy groups expressed fears about using age or clinical frailty scores for crude rationing of intensive care or CPR, not least for younger people with physical or learning disabilities.^{4 5}

Among medical and nursing staff who deal daily with end-of-life care, acutely deteriorating patients, or cardiac arrests, many of the issues involved seem far less contentious. But this topic continues to generate strong reactions, whether we like it or not. If we're to improve the public conversation we need to convey some key messages.

First, DNACPR is specifically about what happens when your heart stops. It's not synonymous with “Do Not Treat” or “Do Not Convey To Hospital,” despite understandable concerns that some health and care workers without adequate training or protocols may be less likely to escalate treatment in deteriorating patients and see it as a “stop” sign.⁶

Second, CPR itself—especially in non-hospital settings and in older people or those with life limiting, long term conditions—affords a lower chance of immediate survival than most people imagine or is depicted on TV.⁷ This is especially true for non-cardiac causes when the heart is the last organ to stop rather than the first: the one year post-CPR survival, even after an in-hospital arrest, is only 10.7% on meta-analysis.⁸ Only one in 10 UK patients receiving CPR outside hospital survives to hospital discharge.^{9 10} Survival rates are lower among care home residents or people at extremes of age or frailty.¹¹ Very high clinical frailty scores have been associated with poor intensive care outcomes.¹² And comatose CPR survivors often live with permanent neurological and functional impairment.¹³

Third, CPR is not some benign, neutral intervention. Those of us who have attended hundreds of arrests know this. Chest compressions, shocks, intubation, and multiple arterial and venepuncture can be physically and emotionally traumatic. To do this to

patients whose chances of a good outcome are low, or who would not choose it had they been asked before the emergency, is not necessarily the right course of action. Denying it may often well be.

Fourth, advance care planning well upstream of emergencies and treatment escalation processes, or when people arrive in acute hospitals, is a good thing: we should be doing more of this. If there's any scandal, it should surely concern the failure to have had and documented these conversations and decisions, not the fact that we've had them. In 2018 the Royal College of Physicians' *Talking About Dying* report called for more training and focus in this area,¹⁴ and a *Nursing Times* article made a similar plea for nurses.¹⁵

Advance care plans make it more likely that people will die in a place of their choosing and have a better experience of end-of-life care.¹⁶ Innovations in practice such as the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT),¹⁷ now being evaluated in a multicentre research project, take decisions beyond a binary “CPR? Yes/No?” process towards one that's more nuanced, patient centred, and goal focused.

As well as being open in the media and using plain language public information (check the *Which?* website for an example¹⁸), we can also help to detoxify the DNACPR issue by talking about it in our day-to-day interactions.

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