Discussing DNACPR

Discussing DNACPR with patients and their families is a core skill for any GP. However, it is something which makes many of us feel anxious. This may be because we are fearful of upsetting our patients, or it may be due to a lack of training or experience.

So, how can we feel less anxious? How can we do it better? Compassion, sensitivity and a bit of practice. That’s all. The important thing to say is that there are no rules. Discussing DNACPR is a hugely personal and individual skill so there is no surprise that every clinician will tackle a DNACPR discussion slightly differently.

Having an individualised framework to discuss DNACPR is the key. You need a framework that suits your personality, your turn of phrase, your communication style. Once established in your mind, it will enable you to lead a patient through a DNACPR discussion with confidence.

With all of that in mind, here is my framework. This is my way. It seems to work for me, most of the time!

**Before you begin…..**

- Know the patient and their context
  - Illness trajectory, likely prognosis, awareness and insight
- Be clear about the benefit/burden balance of the treatment (ie CPR)
  - Would CPR work, in terms of medically successful outcome?
- Consider the benefit/burden balance of the discussion
  - Any indication of willingness to engage in advance care planning conversations?
  - Is talking about death something this patient can get their head around without harmful distress at the moment (or ever)?
  - For some patients it will never be the right thing
  - For many patients it is a relief and a reassurance
- Consider timing of discussion and who should discuss?
  - *Right person at the right time*
  - Experienced doctor or nurse trained in communication skills
  - Established relationship (of trust) with patient
**Remember….**

- Rather than discussing DNACPR in isolation, try addressing as part of a wider discussion regarding advance care planning and preferred place of care.
- DNACPR discussions are often easier to have at an earlier stage in a patient’s illness, rather than waiting until crisis point.
- When discussing DNACPR, deliver information in small chunks and check patient’s understanding as you go. Use the same communication framework as you would with a ‘breaking bad news’ scenario.
- In the context of palliative care, where death is anticipated, discussing DNACPR can allow natural death and prevent unwanted or futile attempts at CPR. This is why we discuss it. We only get one chance to get EOLC right.

**What to say…..**

**Scenario 1**

Frail, cachectic, 80 year old man with advanced metastatic cancer, aware he is dying, (had a good life and ready to die), wants to die at home, doesn’t want to go to hospital

- Arrest anticipatable, CPR futile, end of life care

If patient/relative acknowledges deteriorating condition and that end of life is approaching, then this discussion is more straightforward. Set discussion in context of illness and end of life goals/concerns eg. death at home, peaceful, dignified, pain free, avoid hospital admission etc.

**Intro:** Start discussion by acknowledging changing condition, increasing frailty, deteriorating function etc. Acknowledge that this may mean time is getting shorter and that they might die soon (may be part of prognosis discussion/preferred place of care discussion).

**Reassure patient/relative:** when the time comes, it is important that we do everything we can to ensure that you die peacefully, to allow you a natural dignified death (and allow you to die at home, if preferred place of care is home). Some patients are very relieved to here that you won’t do anything to prolong their lives, especially those that are ready. This is a good point to reassure them – although we can’t make this happen any quicker, what we can do is promise you that we won’t do anything to make it last any longer, won’t do anything to prolong your life.

**Explain form:** One of the most important things we can do is to give you a special form. It’s called a ‘Do not resuscitate’ form. It means that when you die, we won’t try to restart your heart, we won’t try to resuscitate you, because we know it wouldn’t work. It wouldn’t bring you back. Instead of a Do not resuscitate form, I like to think
of it as a form which, when the time comes, will allow you to die peacefully, with dignity (at home).

**Talk through practicalities:** It’s important that everyone who is looking after you knows that you have this form. Explain the need to keep it somewhere important eg DN notes, on the fridge and that you will inform everyone it is there. Also, advise relatives about who to contact/who not to contact if loved one becomes more unwell or if they die at home. This simple piece of information can make the difference in preventing unwanted and futile attempts at CPR.

**Scenario 2**

Reasonably fit 65 year old lady with locally advanced rectal cancer, recent chemo and new diagnosis of liver mets

- Arrest anticipatable (cancer, recent chemo) but CPR *might* work

This is not as difficult as perhaps it may seem. Essentially, your aim is to share the uncertainty of the outcome of CPR with the patient and establish what their wishes would be if that situation were to arise. There are several ways to lead into this conversation. Here are a few options. You could choose to do one or all three.

**a) Gauge patient’s understanding of illness:** What did the doctors say to you about what to expect from your illness? What did the doctors say to about what to expect from your treatment? Do you have any questions about your illness, how it may change or develop?

**b) Set in context of illness, deteriorating condition:** How have things changed for you over the last couple of months? Think about how you were a month ago - how have things changed between then and now? Try to get patient to identify deterioration themselves. Acknowledge that you too see them as ‘less well’, that things are changing. Highlight deteriorating condition, more hospital admissions, increased SOB, can’t do the stairs anymore, in bed more of the time etc.

**c) Set in context of ‘thinking about the future:** Do you think about the future at all, about how things might change? Is there anything about what’s to come that worries you?

Then,

**Introduce idea of advanced care planning:** I wonder if it would be helpful to talk about what might happen when you become more unwell. Acknowledge that this can be difficult, especially as we don’t know what future holds, but explain that planning for the future is often easier to do in advance rather than waiting for a crisis. Offer opportunity to have discussion with friend or family there.

**Explain your role:** Part of my role is to try to make sure the right things are done for you, in line with what you would want. Equally, part of my role is to make sure the wrong things aren’t done for you.
**Address place of care:** This is as good a point as any to introduce preferred place of care and ceiling of care. *If you become more unwell, would you have a preference as to where you would be looked after?* You may also choose to address ceilings of care as part of this discussion. *What about if you got another chest infection? Would you want antibiotics? What if that meant you had to be admitted to hospital?*

**Address CPR:** *I want to talk to you about a very specific situation. I chat about this with most people whom I look after. It is about resuscitation. CPR? Has anyone ever spoken to you about this before?* A patient’s response will guide the rest of this conversation. The woman who, looking terrified, tentatively replies ‘no’ will require a very different response from the woman who triumphantly replies ‘goodness yes, I’ve got the red form, carry it around in my handbag everywhere!’

**Explanation:** Check that patient is happy to chat about this now. Again, offer to delay conversation till family/friend is present. Go on to explain - *Resuscitation refers to a very specific circumstance where your heart stops and your breathing stops. This may be due to a sudden collapse, something unexpected, like a heart attack or a blood clot in the lung. Or, it may be at the very end of your life, when you heart/breathing stops as a natural part of dying.*

*Because you are doing ok at the moment, if your heart/breathing was to stop suddenly, there is a chance that we could restart it by doing CPR, resuscitation. What I’m not sure about, is whether it would work or not. There is a possibility CPR might work, it might get the heart started again. Equally though, there is a possibility it wouldn’t work. You should go on to explain here that if CPR didn’t work, it would mean they die. You should also explain that even if the heart was started again, there is no guarantee the person would return to their baseline health. Explain risk of brain damage, machine dependent living, prolonged hospital admission, reduced functional status. If you don’t do this, then the person’s right to choose CPR vs DNACPR is meaningless.*

At this point, I find it helpful to talk in general terms. This seems to put the discussion into neutral territory and gives the patient some guidance in how they may respond. It hasn’t got me into trouble yet! *When I talk with most folk about this, in my experience, people often fall into one of two categories. Those who say, ‘if my time’s up, my time’s up, just let me go, don’t try and resuscitate me’. Then, there are those that say ‘do whatever you can, try and keep me alive, at all costs’. Do you have any strong feelings as to what you would like to happen if it were you? Which camp would you be in? Would you like us to try and restart your heart? etc etc. Explain the reason you ask – because there is a special form that I can give to you if you don’t want to be resuscitated. It would mean we would act in accordance with your wishes.*

**Practicalities:** Reassure patient that all health care professionals will be notified of outcome of discussion. If DNACPR form completed, follow practical instructions as per scenario 1. If patient chooses to be resuscitated (ie no DNACPR form), it may be helpful to address that this may need revisiting in the future - *there may come a time in the future when you become less well, it may become clear that CPR would no longer work for you. If we get to that place, it’s important that we come back to this discussion and talk some more. Is that ok?* Setting the scene like this will certainly make the next discussion easier when it comes.
Scenario 3

55 year old lady with breast cancer, multiple bone mets, recent PE.

- Arrest anticipatable, CPR futile

CPR will not work so won’t be offered, irrespective of what patient’s own wishes/perceptions are. The challenge is to convey this information sensitively and meaningfully to a patient and their family. I’d suggest using the same beginning detailed in scenario 2. Introduce CPR in the same way as follows.

Address CPR: I want to talk to you about a very specific situation. I chat about this with most people whom I look after. It is about resuscitation. CPR? Has anyone ever spoken to you about this before?

Explanation: Check that patient is happy to chat about this now. Again, offer to delay conversation til family/friend is present. Go on to explain - Resuscitation refers to a very specific circumstance where your heart stops and your breathing stops. This may be due to a sudden collapse, something unexpected, like a heart attack or a blood clot in the lung. Or, it may be at the very end of your life, when you heart/breathing stops as a natural part of dying.

Because of your illness and how poorly you are (add in appropriate examples eg blood clots, frailty, bones breaking during resus attempt etc) we know that if your heart and breathing were to stop, we wouldn’t be able to restart them. If we tried to resuscitate you, it would be very distressing, for you physically and for whoever was watching, maybe your family. It would be very distressing, but wouldn’t change anything. We wouldn’t be able to get you back.

Because we know that CPR wouldn’t work for you, it is important that we try to ensure that this doesn’t happen. There is a special form that we would recommend. It’s called a do not resuscitate form. A DNACPR form. Having this form means we can try to do the right things for you. It would mean that if your heart did stop, we would look after you, accept that that was the natural end to your life, and ensure that you could die peacefully and comfortably.

Practicalities: as detailed above

Scenario 4

46 year old man with advanced pancreatic cancer and overwhelming anxiety. Has clearly expressed an opinion that he does not want to talk about the future or dying.

- Arrest anticipatable, CPR futile, inappropriate to discuss

Inform relevant health care professionals involved, including OOH. Communicate that, in your opinion, CPR would not work in the event of an arrest, but that you have been unable to provide the patient with a DNACPR form and explain reason if appropriate. You can complete a DNACPR form and file in patient case notes. If a DNACPR patient is at home without a form, there is always the risk of inappropriate paramedic and police intervention, including CPR.