

Resuscitation discussions: learning from Covid-19

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The Covid-19 pandemic has had an unprecedented effect on health care systems across the world. For doctors in the United Kingdom (UK), there have been drastic changes in working environments. Junior doctors' training rotations were suspended, meaning that trainees have been staying in the same post since December. For myself, this means a further 4 months working as a second-year doctor (PGY2) in accident and emergency (A&E).

I have usually been the first doctor to interact with and assess patients before either admitting them to a ward or discharging them home. Many of these patients have had symptoms of Covid-19 on arrival, many have been unwell, and many have been frail with multiple co-morbidities. The current pandemic has increased the urgency of making sure that these patients have appropriate treatments and, importantly, discussions about escalation of treatment. Treatment escalation refers to the planning of care of a patient at risk of deteriorating. As such, do not attempt cardiopulmonary resuscitation (DNACPR) discussions have been occurring when patients are still in the emergency department.

The current pandemic has increased the urgency of making sure that these patients have appropriate treatments and escalation of treatment.

Initiating DNACPR discussions is often found to be difficult for medical staff, with health professionals deterred by fear of causing distress, attracting complaints and time constraints.¹ Additionally, in the UK, an evidence synthesis has found that there is variation in hospital implementation of national guidelines surrounding DNACPR decisions,² further complicating matters.

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The current UK recommendation is to discuss treatment escalation plans at the earliest and most practical opportunity.¹ The literature suggests that patients prefer having such discussions on admission to hospital or following acute deterioration¹ and that, when these discussions are part of overall treatment escalation plans, patients have improved clarity about goals of care.²

With the complications brought about by Covid-19, however, discussions have become more ethically complex. Relatives can play a significant role during such sensitive discussions about resuscitation by supporting the patient to communicate their wishes or simply by providing a familiar face to discuss with. Furthermore, if a patient lacks capacity, the discussion about resuscitation would usually be conducted with relatives, unless such discussion had previously been refused by the patient when they had capacity. However, due to the pandemic, unless a patient cannot communicate for themselves or is approaching the end of life, the patient must attend hospital alone. Relatives have been told to remain at home.

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Previous work has indicated that patients prefer to have these discussions with clinicians with whom they have an established relationship, such as their regular family doctor or general practitioner.¹ Now, patients are having these discussions with doctors they do not know, with these doctors likely to be junior and potentially at a less experienced level. It should be noted that any doctor with a full license to practice in the UK (a second-year doctor or above) can have this discussion and sign a DNACPR form, while a senior responsible clinician should review this decision within 24 hours of it being signed.

As a part of postgraduate doctor training, second-year doctors in the UK are expected to discuss management options, including DNACPR discussions, with patients and show evidence of this in their training portfolio. To discuss such sensitive issues is understandably a challenge for inexperienced doctors. A survey of junior doctors in Bristol, UK, in 2016 found that they do not feel adequately prepared or confident to have DNACPR discussions³ and that most learning around DNACPR discussion had occurred during undergraduate training at medical school or from observing senior colleagues. Furthermore, while junior doctors are expected to 'contribute to the care of patients and their families at the end of life',⁴ by the time they left medical school, most felt that their undergraduate preparation did not prepare them well enough for such discussions.³ An exploratory investigation into DNACPR decisions from 43 countries highlighted a common theme that the lack of teaching for end-of-life issues at medical school meant that doctors had not developed the communication skills necessary to discuss DNACPR decisions.⁵

In light of the current circumstances, training around treatment escalation and DNACPR discussions remains an unmet need for junior doctors and undergraduate medical students. Indeed, an integrative review into DNACPR conversations in the UK recommended the introduction of advanced communication skills training during medical school and extending this into specialist medical training.¹ From my experience in A&E, I would strongly argue for the introduction of escalation and DNACPR discussions throughout medical training. Such training should cover the ethical and legal aspects of DNACPR forms, in addition to communication skills for having these challenging discussions. I believe that such education training would increase knowledge, skills and confidence around discussing the subject and would be the first step in addressing the deficiencies in relation to DNACPR decisions described in the literature.^{1,2}

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DECLARATIONS

Ethical approval was not deemed necessary for this work.

The authors declare no conflicts of interest.

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REFERENCES

1. Hall CC, Lugton J, Spiller JA, Carduff E. CPR decision-making conversations in the UK: an integrative review. *BMJ Supportive & Palliative Care* 2019;9(1):1-11.
2. Perkins GD, Griffiths F, Slowther A-M, George R, Fritz Z, Satherley P, et al. Do-not-attempt-cardiopulmonary-resuscitation decisions: an evidence synthesis. Southampton (UK): NIHR Journals Library; 2016 Apr. (Health Services and Delivery Research, No. 4.11.). Available from: <https://www.ncbi.nlm.nih.gov/books/NBK355498/>. <https://doi.org/10.3310/hsdr04110>. Accessed on 18 August 2020.
3. Heil K, Reid C. Preparing junior doctors for discussing DNACPR with patients – a bit of trial and error? Available from: <https://apmonline.org/wp-content/uploads/2017/11/Preparing-junior-doctors-for-discussing-DNACPR-with-Patients.pdf>. Accessed on 18 August 2020.
4. General Medical Council. Outcomes for Graduates, Outcomes 2 – Professional skills. Available from: <https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/outcomes-for-graduates/outcomes-for-graduates/outcomes-2---professional-skills>. Accessed on 02 October 2020.
5. Gibbs A, Malyon AC, Fritz Z. Themes and variations: an exploratory international investigation into resuscitation decision-making. *Resuscitation* 2016;103:75-81. <https://doi.org/10.1016/j.resuscitation.2016.01.020>

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