Letter to the Editor

Can the COVID-19 crisis strengthen our treatment escalation planning and resuscitation decision making?

Sir,

The COVID-19 pandemic presents mammoth challenges for our NHS. I would suggest however that through this storm we should also seek hope that we may learn things that will improve patient care going forward. I would suggest it should be mandatory for all medical inpatients to have a Treatment Escalation Plan (TEP) or similar completed on admission and the appropriateness reviewed throughout their inpatient stay. This is one of the few things we can offer to these patients as physicians and as geriatricians we are well placed to lead and sustain this change.

Early discussion around appropriate ceiling of care can give patients and their carers opportunity to realise the severity of this situation, to discuss death and dying and to consider what they ultimately want the end of their life to look like—giving them some control in a time when we have very little. Appropriate ceilings of care will also prevent the unnecessary viral exposure to staff, decrease inappropriate CPR and free up the time of busy critical care staff to look after patients who would benefit from their expertise.

In 2017 Fritz *et al.* discussed do not attempt cardiopulmonary resuscitation (DNACPR) decision making[1]. The authors discussed how we can make that decision to protect patients from unnecessary and invasive treatments which have little or no chance of success, however concede that there remains some hesitancy in initiating these discussions with particular concerns regarding complaints[2]. They suggested several approaches to DNACPR and its integration with advanced care planning including TEPs which originate in the UK and also the Canadian Medical Order of Scope of Treatment (MOST). The solution they proposed following public consultation—the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)—includes a scale on which patients can demonstrate whether they wished treatment to focus on measures to sustain life or those which prioritise comfort. This personal preference sits alongside the expectations and limits decided by their clinician.

Most if not all of us will all have some form of tool available in our hospitals and community practices. Certainly we now have a Scotland-wide DNACPR form with supporting documentation for clinicians, patients and families. The ReSPECT tool is also available from the Resuscitation Council (UK) website along with a guide on how to implement its use and a list of other sites across the UK who currently use it. Now is not the time to reinvent documentation but to use the tools we have and ensure we are having early and frank discussions with patients and their loved ones about their wishes, co-morbidity and frailty and what this means for them. COVID-19 brings its own separate issues with changes to advanced life support practices to limit viral exposures and with a marked increase in futility in a treatment which was never intended for patients suffering from irreversible conditions[3].

Early in these discussions patients may frequently underestimate their own ill-health and believe they would benefit from more aggressive treatments such as mechanical ventilation or CPR. It is our role to explain what these treatments mean, the burden they bring, and address common misconceptions. We must make clear to patients that their co-morbidity and or frailty may preclude them from intensive treatments—now in a time of crisis more than ever. I hope we can use the communication skills we will develop over the coming weeks and months to continue to have these discussions early at the front door and make this a matter of routine in all medical admissions to remove some of the taboo that currently exists around discussing death, dying and advanced care planning.

Luke McIntosh
University Hospital Ayr – Medicine, Dalmellington Road Ayr KA6 6DX, United Kingdom of Great Britain and Northern Ireland
Address correspondence to: Luke McIntosh.
Email: lukemcintosh@nhs.net

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