**Why we need to think about DNACPR before we talk to patients**

**This is such a useful and compassionate article on why we need to talk to our patients about DNACPR, it was written by Dr Kathryn Mannix a Palliative Care Physician who is passionate to get us all better acquainted with the idea of dying well.**

***I’ve highlighted the key phrases in bold, I’m sorry if that’s annoying. Nicola***

**These are Kathryn’s words of wisdom:**

I have had a lot of questions recently about DNACPR orders (also known in different parts of the world as DNR or ). I thought it might be helpful to look at the issue in more detail.

**Cardio-pulmonary resuscitation (CPR) is First Aid when someone’s heart stops suddenly and unexpectedly**. As soon as the heart stops, the blood-flow that carries oxygen from our lungs to all our other organs stops. Without oxygen, those organs rapidly become damaged, and the most sensitive of all is the brain. Without oxygen, the brain is dead within 6 minutes.

This makes CPR a fast-action emergency: if a person has collapsed because their heart has stopped beating, then CPR needs to be commenced straight away. The blood is forced to circulate the body by applying repeated, forceful compressions to the chest. Pressing gently won’t work, and we often feel people’s ribs snap as we press on their chest.

CPR is only First Aid. It keeps the rest of our organs alive until our heart can be re-started, which it sometimes can be.

Sometimes? Yes, only sometimes. In TV soaps we see people sitting up and chatting, sipping a cup of tea, after CPR. **TV hospitals have a massive 50-80% success rate (someone has measured this stuff!). In real life, the figure is around 10%,** a bit higher if the person is already in hospital surrounded by experts and resuscitation equipment. A significant proportion of survivors will never sit up and drink a cup of tea again: their brains are permanently damaged by the low oxygen levels during the period that their circulation isn’t being pumped by their heart. Many will live in care facilities for the rest of their lives. A few, often sportspeople with strong physiques, make great recoveries and get splashed all over the news. So the stories we see and hear about CPR are the success stories. Nobody talks about the 90% deaths or the life-long comas.

There’s some more information about CPR and success rates here: [https://www.verywellhealth.com/brain-activity-after-cardiac…](https://www.verywellhealth.com/brain-activity-after-cardiac-arrest-1298429?fbclid=IwAR3o-0Sl_xAWYRxl0wkbdQu9GkGhXl7hfcv4a9JYUiUsKvsqSVnMjwmh1mY)

Let’s think about the circumstances in which somebody’s heart might stop beating. Can that help us to know how likely it is that CPR will save them? Well, yes, it can.

**The people whose lives are saved by CPR tend to be younger rather than older; to have organs that are healthy rather than damaged; and to be somewhere nearby people who know how to do CPR,** and with access to a defibrillator when they collapse. This means that their cardiac arrest (literally: ‘heart stopped in its tracks’) is sudden, unexpected and takes place when they are otherwise well. They need First Aid CPR, and the more of us who know how to give CPR, the better.

There’s advice about how to give CPR here:  
[https://www.resus.org.uk/faqs/faqs-cpr/](https://l.facebook.com/l.php?u=https%3A%2F%2Fwww.resus.org.uk%2Ffaqs%2Ffaqs-cpr%2F%3Ffbclid%3DIwAR3H6Mc4aw1DE2UAommtSOoxblMMb_WTOM-XPvPEJfI7PzUboektrWVPZhk&h=AT28IKzo4ZiOSubgEzYXeKeh5IzQr9aXuZmn7pqAiOofTIczM3c1wn1xImCsQvkO8tHONjFu-LeUrQe36t9z_L9mH6fDXgPRRMosJ_GBTvl80njot7xEGPYaYMjOOeR6iIPtabNX1ZsPZ6QQY9oChZwpQdV1ebVKZgzQg_XzdoJ18Y2WNkTZ9OhEp85rAIoRLMvHvXVxQoTYnrM_EkIOZvTSZzu0zyk149L74Fb6duM-2r7xs4uyUNVcIkITOKlPnHAIIoXHUzQCioEs9lYeRmUq3Hg5muQEZ-NAt3P4q2Ky4CnacvYtW_41HEE-5IjZHHPXZld5yLVBGvKUwkd_Oes4rTCM1IRF-ZHJr8JoiSjAYuvVgtPcH7nfcITEALJiCsnL6ToVCaW0u8d3DmXyrvnq6UnPwqUUFrIEAVWLh8z1qlNQhiPJ9rRQY_Yf0YkeTfhIOxyBRJ7tN0tipkd4bekZJTou9TEwUQnESlsPs58ppqVGd5uFsk9RKKEKW-uzU2i_CqjZ7b98dZnP6T_pWYD0aPz5_IphUQsL2auOIHCevfpDMefjT2yf-A_AQWTc2466dnAr_8KvK0F7jJC-zsH9HDe8wM1sq4t5QSarXU-3Z8xwSC_2Cl-Y81clk1m7Q5DIZg)

These facts mean, of course, that the people least likely to be saved by CPR tend to be older rather than younger; to have organs that are already damaged either by simply being old (our lungs are usually as old as we are), by having had a previous illness that left us damaged after we recovered, or damage caused by working in dusty environments, exposure to chemicals, smoking etc; by a long-term condition like lung disease, heart disease, kidney disease etc that we live with; or by recently becoming so very unwell that our organs are experiencing new damage at the time when the cardiac arrest takes place.

During the Coronavirus pandemic, most of us will survive even if we catch the virus. Some of us will get a short illness with a cough, a sore throat, fever and muscle aches and we’ll stay at home until we feel better (and until we are allowed to go out again).

Some of us will get sicker than that: we may have a serious lung infection from the virus, so severe that we need hospital treatment. I posted previously about hospital treatment, and when ventilators will or won’t help us survive (here if you want to check it out [https://www.facebook.com/DrKathrynMannix/posts/2949195348436749?\_\_tn\_\_=K-R](https://www.facebook.com/DrKathrynMannix/posts/2949195348436749?__xts__%5B0%5D=68.ARAjcwI-XL0-rqaO8OBGiNXbUoEDsTHcKdjHOz6UcYvvJax5QnA70LmgNm0v05FoWyOnwRcKO8Uwf1ej6HN52s-55tqcXXNoC0K9iZFCtA5DNKBLDn_efHrFb4TzdWy1N-BGVYgjBggmXqixQxxi4WFVJaaBWKf8neOwSWL4Iit0FsiVltD86tWNhrXMxhQW4RsRlZZL7Wak4iVzIcoxuW9A9CKpD-ibbrGHMgpXO8AQnC5G-kkvFcqA6v9-uLendP_wMJIqyCI0L2XugCpThIDdcdjWb2Wtwg-XJ2A59TvXXucjakc4bbr_Zw0zt9fX4wQ9I2lF1oKbLFop6M-EAA6fwPwP&__tn__=K-R) ).

Now it’s time to think about when and whether CPR will help us. **The question is not 'Do you want to be resuscitated?'** as though resus is as simple as pressing a button, with success guaranteed. If it were that easy, everyone would want CPR. **The choice we have is, if CPR might help, would we want it or not?**

There are three scenarios to contemplate, to consider what is the best response for each person.

**Scenario 1**. If someone is otherwise well, has relatively healthy organs and their heart stops suddenly and unexpectedly, then CPR is the First Aid that may save their life. They have around a 10% chance of surviving, although many won’t ever be well again.

If this could be you, would you choose to have CPR? If you would, and many of us would, that’s no problem. People who know how to do CPR will always start first (seconds matter, remember) and ask whether this person would want CPR later.

But if you think you wouldn’t want to take the risk of surviving in an incapacitated way, you may decide you wouldn’t want CPR to be started. You’ve probably never even thought about that possibility. But in this time of heightened awareness, lots of us are thinking about things in a new way.

If you wouldn’t want CPR, it’s your right to refuse it. But you won’t be able to refuse it at the point it might be needed, because you’ll be unconscious within seconds of your heart stopping. So one of the reasons for a Do Not Attempt Cardiopulmonary Resuscitation order (DNACPR) is because a person has thought about it and decided that they don’t want it. We all have the right to decide not to have any medical treatment, including CPR, for ourselves.

**Scenario 2**. If someone has long-term organ damage and then they develop a sudden problem that stops their heart, then it may be that their damaged organs can’t survive a cardiac arrest no matter how promptly CPR is started. This applies to some heart conditions, some lung diseases, some kidney problems and a variety of other health challenges that many of us already live with, even though we feel well enough from day to day. For example, if someone has very weak bones, they could not survive the chest compressions of CPR.

This is a situation you could probably only be aware of if your doctor or a nurse specialising in your condition discussed it with you. **Rather than being a decision that you need to make about whether you would accept CPR or not, this is a medical reality that we need to be told about**. So, just as having antibiotics for a viral sore throat won’t work so we shouldn’t start them, in some people we know ahead of time that CPR won’t work if their heart stops. They need the protection of a DNACPR order so that if their heart stops, nobody breaks their ribs or bursts their lungs by trying CPR that won’t succeed.

**Scenario 3**. If someone is so sick from any condition at all, whether it’s coronavirus that they caught a couple of weeks ago, or a cancer they have had for a long time, or a liver complaint that’s made them seriously ill, or a problem with their heart, lungs, immune system – it could be anything – if someone is so sick that they are close to dying, then a series of things will happen. Only the speed of the process varies.

The vital organs all get weaker and less effective. The body gets wearier, and the person begins to experience periods of becoming unconscious. Gradually, they lapse into permanent unconsciousness as their brain begins to switch off all its activity. And finally, their breathing will slow, and gently stop, and then their heart will stop. This is the process of ordinary dying, and it’s pretty much the same sequence whatever it is that we die of. I’ve talked about it in more detail here: [https://www.facebook.com/DrKathrynMannix/posts/2959419307414353](https://www.facebook.com/DrKathrynMannix/posts/2959419307414353?__xts__%5B0%5D=68.ARAjcwI-XL0-rqaO8OBGiNXbUoEDsTHcKdjHOz6UcYvvJax5QnA70LmgNm0v05FoWyOnwRcKO8Uwf1ej6HN52s-55tqcXXNoC0K9iZFCtA5DNKBLDn_efHrFb4TzdWy1N-BGVYgjBggmXqixQxxi4WFVJaaBWKf8neOwSWL4Iit0FsiVltD86tWNhrXMxhQW4RsRlZZL7Wak4iVzIcoxuW9A9CKpD-ibbrGHMgpXO8AQnC5G-kkvFcqA6v9-uLendP_wMJIqyCI0L2XugCpThIDdcdjWb2Wtwg-XJ2A59TvXXucjakc4bbr_Zw0zt9fX4wQ9I2lF1oKbLFop6M-EAA6fwPwP&__tn__=K-R) and, of course, I’ve written a whole book about it.

**In this scenario, we are talking about dying. The heart stops last. Everything else has stopped. The heart can’t be re-started. CPR will not change anything. It will not rescue someone from anticipated dying. CPR is not a treatment for them now. At death there are no choices: not CPR or brain surgery or a heart transplant.**

So why would this person need a DNACPR order? Well, the difficulty is that health care staff, and paramedics, may only meet us at the point where we are very close to death. They may not be aware that we are already dying, that our family anticipate our imminent death, that our goodbyes have been said and we are hoping for that gradual, peaceful end of life. So without a DNACPR order, they may leap into action – family out of the room, compressions and electric shocks on the chest, the whole works. And that’s no way to die. So now the DNACPR order is our protection certificate: it really means ‘Allow Natural Dying’ in these circumstances.

**\*\*\*CPR only works, and then only sometimes, when the heart stops first.  
In dying, the heart stops last. No options left.\*\*\***

I watched a skilled GP have this conversation with my elderly, frail relative. My relative was nearly 90. She told the GP she wouldn’t want a lot of fuss, blue flashing lights and sirens, lots of treatment, when the inevitable time came that she was approaching her death. At the end of the conversation, the GP asked if she could make a suggestion to her.

**'Can I give you a certificate, to tell everybody that, if your heart stops, they should hold your hand instead of thumping on your chest?’ My relative was delighted with her 'Protection from CPR certificate.' I've used that phrase during explanations ever since.**

My relative had that conversation three years ago, about a year before her death. Her GP was proactive in having honest conversations about what medicine can and cannot achieve, with all her patients over 80 and any with serious, life-limiting illnesses of any age. Some may go on to die of the illness they already have; many will meet their end when a different illness strikes their already weakened body.

This is the conversation that GPs are now being asked to have with all their vulnerable patients, in a hurry if they haven’t already had this conversation in the past. It's about determining what options we would accept, should they be options for us. If a treatment can’t help, it won't be offered. This has caused a lot of worry and misunderstanding about getting ‘no treatment’ or having ‘no care.’

Just because someone has a DNACPR order doesn’t mean they can’t go to hospital, or even go to ICU. It simply means that either they wouldn’t accept CPR even if it had a small chance of helping them, or that it’s already medically apparent that CPR won’t work for them. People who have DNACPR orders still have hip replacements and hospital treatment for chest infections; they get IV drips and the same drug treatments as people without DNACPR orders. It’s only about CPR. All other care that is likely to help them will still be offered.

**Advance Care Planning ACP conversations are not setting out to limit choices, but to explore which treatments we would or would not accept.** It’s a conversation that makes no unrealistic promises. It gives us back autonomy. And it recognises that there are still no treatments for death.

There’s lots of helpful advice about this here: [http://talkcpr.wales/](https://l.facebook.com/l.php?u=http%3A%2F%2Ftalkcpr.wales%2F%3Ffbclid%3DIwAR1i27zAzQpCkM8MnmtWwgJRF8qfDXP5UWivy4-skSo3vlu2rZ75MFzQwOo&h=AT0Ej67i5tQSssHTvC07x-pXqechq4wwpcLzw8gBvQ9CHokSAIJTQrSFBO7D6lvYJsTvl7ZYumRsG8p3hVZzob7bOdKMa80-6HNks6M0vNAlI0tNBU3cx9VDfkyiJptEapDLboWJPYMTZO27XpEiYYzr3E2MOPILo1u5Y1OpcT1hBCJjLfe5fV7dhTAxxjagJZ2C0NhdgsNC-nRY7tLuvWRHAWnhfkYqa2IIl5fIvI-0woxvZyV1zF-WRJQwsLhYpQB1GnjthbOCS3dPQAg1GXwA7UTgl2SumjxytGKmp2-QUt5xhjDldHQJOce1leR7Zol-75SeQN8fAnYUfUAWObMiIlkjSde22k_0MLu-JmLfzvBGpsFZXIEMp8i3mFOImVWqrFhKdrtemuBOL5F5pbFk4qWKTNJIG9TjunWxUM6y-5xcqYpSSPQAEAzAJbMV_YUA9czMs791GN8zmSPzVoOXq-zL6K6JDVasymhP1iFjuBF6bJ4MFfQcoB1Vj8v7OMBPKR0auSCP_kMdP-ncVevqFsozjuUF-88BqWyzdWHUiasZMqTtcQ1esyUG5KMFyQ54JBBQVFK-v-7H6A5TOhTKiHPun8h6mc0v1wLRs_I8jP1kD2ZjR62fsJiDXe-7kUPzAw)

THIS IS WHY WE NEED TO DISCUSS WITH OUR GP or another person who understands our health very well. This is why all GPs in the UK are currently trying to contact everyone over the age of 70 (remember: our organs are as old as we are); everyone who has a long-term condition who may struggle to recover from a coronavirus infection (remember: we’re all more likely to survive than not); everyone who is immuno-compromised for any reason.

Some of the GP letters that have hit the news sound a bit draconian and scary, but all of them are intended to pave the way for sensitive, careful discussions, person by person.

Previously this would have been in your home, over a cuppa. Sadly, right now it has to be over the phone. We’re all finding that sad. We wish we could be with you for this important conversation.

The more you’ve had a chance to think about it in advance, the more you can ask and the better you’ll feel when it’s your turn to have the conversation. Some doctors are managing 3-way conversations so a family member or friend can listen in and support you, so you might like to ask for that, too.

Remember to talk to your beloveds so they know your decisions. If you’re ever really sick (and I hope you’re not), then we doctors will need to ask them about your decisions.

I’ll post soon about how to make a legally-binding Advance Decision to Refuse Treatment, or to appoint someone you trust as your Attorney to speak legally on your behalf. Meanwhile, I hope you stay well, think hard, and talk to your loved ones.

And then have a hard-earned cup of tea. Or a coffee. Or whatever takes your fancy. You deserve it.