Resuscitation of patients with active Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status after out-of-hospital cardiac arrest

Barnard EBG[1,2], Sandbach DD[1], Nicholls T[3], Wilson A[1], and Ercole A[1,4,*]

[1]East Anglian Air Ambulance, Hangar E, Gambling Close, Norwich Airport, Norwich, UK
[2]Academic Department of Military Emergency Medicine, Royal Centre for Defence Medicine (Research & Academia), Birmingham, UK
[3]East of England Ambulance Service NHS Trust, Whiting Way, Melbourn, UK
[4]University of Cambridge Division of Anaesthesia, Addenbrooke's Hospital, Cambridge, UK
[*]Corresponding author. Email: ae105@cam.ac.uk

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Letter to the Editor

Victims of out-of-hospital cardiac arrest (OHCA) will often already be living with serious or life-threatening chronic co-morbidities. Many patients express wishes that they would not want to be resuscitated in the event of a cardiac arrest. Analysis of calls to Compassion in Dying's End-of-Life Rights Information Line demonstrated public concerns about being resuscitated against their wishes [1]. Nevertheless resuscitation of patients with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions does sometimes occur in the hospital setting [2].

We recently reported outcomes after OHCA in a cohort of 9,109 patients in which resuscitation was started in the East of England [3] between 2015 and 2017. In the course of this work, we identified 139 patients with a previous DNACPR decision. Of these, 85 received 'invasive' advanced treatments (defined as any of endotracheal intubation, supraglottic airway insertion, intravenous access, administration of any drug or defibrillation). In this subgroup, two patients had return of spontaneous circulation (ROSC) before the ambulance service arrived, 21 had a subsequent ROSC, and 10 survived to hospital arrival (with one further surviving to hospital discharge). ROSC did not occur in patients who did not receive an invasive intervention. 129 (92.8%) patients were at home when they had their cardiac arrest (where their DNACPR decision was presumably likely to be known by those around them)– of these 78 received 'invasive' treatments.

This raises questions about how effective the DNACPR decisions process is in respecting the wishes of the patient. From our data we can only speculate but since it seems likely that in many cases ambulances were called by carers or relatives, this raises the questions of adequacy of their shared knowledge and understanding.

There has been much attention given to communication of DNACPR decision making with patients, and also relatives [1] who are often consulted as proxies [4]. Whilst relatives may rarely try to over-rule resuscitation decisions made by patients [5] in hospitals, intuitively this seems an unlikely explanation in this setting.

It is also possible that patients do not communicate their decisions to those around them, which may be compounded by the current lack of a robust policy to communicate the DNACPR decision to the ambulance service. A more likely scenario is perhaps that carers and relatives are not adequately prepared to recognize and know what to do at this highly stressful time. If this is the case, it represents an educational and supportive gap that has received little attention. Further research is required, but there may be an opportunity through better understanding and education for clinicians to simultaneously help safeguard the autonomy of patients who do not want to be resuscitated and at the same time perhaps ameliorating some of the anxieties of those who are likely to be left behind.

Conflicts of Interest

None.

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