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## General practitioners' views on emergency care treatment plans; an on-line survey

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## General practitioners' views on emergency care treatment plans; an on-line survey

### Abstract

#### *Background*

A holistic approach to emergency care treatment planning is needed to ensure that patients' preferences are considered should their clinical condition deteriorate. To address this Emergency Care and Treatment Plans (ECTPs) have been introduced. Little is known about their use in general practice.

#### *Aim*

To survey general practitioners' (GPs') experiences of, and views on, using ECTPs.

#### *Design and Setting*

On-line survey of GPs practising in England.

#### *Method*

A survey of 841 GPs using the monthly on-line survey provided by Medeconnect, a market research company.

#### *Results*

ECTP forms were used by 49% of respondents' practices (84% of these were Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) plans); 51% used do not attempt cardio-pulmonary resuscitation (DNACPR) forms. GPs are the predominant professional group completing ECTPs in the community. There was broad support for a wider range of community-based health and social care professionals being able to complete ECTPs. There was no system for reviewing ECTPs in 20% of respondents' practices.

When compared to using a DNACPR form GPs using a ReSPECT form for emergency care treatment planning were more comfortable having these conversations with patients (OR=1.72, 95% CI 1.1 to 2.69) and family members (OR=1.85 (95% CI 1.19 to 2.87).

#### *Conclusion*

The potential benefits and challenges of widening the pool of health and social care professionals initiating and / or completing the ECTP process needs consideration. ReSPECT plans appears to make GPs more comfortable with ECTP discussions supporting their implementation. Practice-based systems for reviewing ECTP decisions should be strengthened.

Keywords

DNACPR, End of Life, ReSPECT forms, Emergency care treat planning, primary care, electronic survey

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**Where this fits.**

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a particular model of Emergency Care and Treatment Plan (ECTP) that is currently being implemented across primary and secondary care in many areas of the UK.

Little is known about the use of ECTPs in primary care.

This research found general practitioners are more comfortable having a ReSPECT conversation than other forms of ECTP conversation.

The potential benefits, and challenges, of widening the pool of health and social care professionals initiating and / or completing ECTPs, and of strengthening practice-based processes for their review, needs consideration.

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## General practitioners' views on emergency care treatment plans; an on-line survey

### Background

Using 'Do Not Attempt CardioPulmonary Resuscitation' (DNACPR) decisions to help future decision making for people with a life-threatening condition is well established in both primary and secondary care.(1) These do not, however, convey substantial clinical information, or what an individual's treatment preferences might be, nor consider which other treatments might, or might not, be appropriate should their clinical condition deteriorate.(2-4) In response, there has been a move to a more holistic approach to recording recommendations about future treatment decisions with the development of emergency care treatment plans (ECTPs). These plans encompass broader clinical decision making, whilst still describing DNACPR recommendations. Several models of ECTP have been developed by individual NHS Trusts or regional health care systems in the UK.(5-8) In 2016 the Resuscitation Council UK (RCUK) developed a model of ECTP that was intended to be used nationally across primary and secondary care.(9, 10) By 2023, this model, the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) had been adopted to some extent in 65% of Integrated Care Systems in England (personal communication RCUK).

An evaluation of ReSPECT in early adopting Acute NHS Trusts identified challenges with clinicians suggesting that the conversation, and completion of a ReSPECT plan, would be better in primary care with conversation(s) taking place over a period of time, with a general practitioner (GP) with whom the patient has an ongoing relationship.(11) Focus groups with GPs identified challenges to using ReSPECT in primary care. GPs with experience of completing ReSPECT forms conceptualised them as end-of-life planning documents, limiting the population for whom a plan might be initiated. Recommendations on GP initiated plans differed from those completed in hospitals, reflecting the context in which they were expected to be used.(12)

The COVID-19 pandemic increased focus on the role of ECTP. Regulatory authorities identified the importance of individualised conversations with patients about future treatment decisions, carried out by healthcare professionals with the requisite skills, knowledge and confidence.(13, 14)

Little is known about how GPs view and make use of ECTPs with their patients. We report a national survey measuring GPs' use of ECTPs, their views on using ECTPs in primary care, their readiness to complete plans with their patients, their families or someone important to the patient (henceforth families), and the factors that might influence this.

## Methods

The survey is part of a larger mixed methods evaluation of the use of ECTPs in primary care.<sup>(15)</sup> Informed by our qualitative work in GP practices, and with involvement from our patient and public advisory group, we developed a questionnaire survey to measure the views of GPs working in England regarding the use of ECTPs in primary care (Table 1). For the survey we included DNACPR forms as a type of ECTP, albeit one limited to a single emergency treatment decision.

Key questions of interest were to identify which factors might predict how comfortable GPs were in having ECTP conversations with a patient or family member, assessed using five-point Likert Scales. After developing our initial questions, we refined these using think aloud interviews with six GPs.

We outsourced data collection to Medeconnect, a market research company providing a monthly online survey of 1,000, regionally representative, UK GPs (Appendix 1).<sup>(16)</sup> There are no restrictions on multiple GPs from the same practice completing the survey. The final questions, formatted in an online survey were tested by the company and the research team. These are presented in Tables 2-4.

### *Sample size and statistical analysis*

For a binary outcome (very comfortable or fairly comfortable vs. all other responses) a sample size of 1,000 (the size of the Medeconnect monthly survey) would, if 50% were 'comfortable', provide precision of 6.2%, or if 80% were comfortable a precision of 5%.

In addition to descriptive statistics for each question we present logistic regression analyses investigating the variables associated with how comfortable GPs are in having ECTP discussions with patients or their families. We initially did unadjusted logistic regression analyses with gender, GP role, NHS region, type of area (i.e. major conurbation, large town), years since completion of GP training, and use of ReSPECT form vs. DNACPR or another ECTP as explanatory variables. We then constructed a fully adjusted logistic regression model including all the explanatory variables. As a sensitivity analysis we repeated this using a backward elimination approach.

## Results

The survey ran in November 2022. Only the 841/1,000 GPs surveyed who practised in England were invited to complete it (Appendix 2). We did not achieve our original sample because of the need to gain additional ethics approval to include the devolved nations. Respondents' demographic characteristics were broadly representative of GPs in England, although males and GP partners/principals were over-represented (Table 1). Just over half (51%) of respondents reported their practice used stand-alone

DNACPR forms. ReSPECT forms were used by 41% of and 8% used other ECTP forms (Table 2). There were substantial regional differences in the forms used ranging from three quarters of GPs (79%,80%) in East/West Midlands using ReSPECT forms to DNACPR forms being predominantly used by GPs in London, the North East and North West (76%, 75%, 77%) (Table S1).

Overwhelmingly (93%), respondents reported that within their practices GPs completed ECTPs, and they felt that GPs should be able to complete them (Table 2). However, there were substantial disparities between who was reported as completing ECTPs and who they thought could complete them. Consistently respondents suggested that a wider range of health care professionals should be able to complete the forms. For example, no respondents reported GP trainees (registrars) completing ECTPs in their practice, whereas 62% felt they should be able to do this (Table2). Three quarters (77%) of respondents thought that advanced nurse practitioners should be able to complete ECTPs but only a quarter (28%) reported that this currently happened (Table 2). Similarly, there was broad support for a wide range of community-based health and social care professionals being able to complete ECTPs, with over 80% supporting senior nurses completing them (82% to 95%), half supporting less senior nurses completing the forms (51%, 56%) and a quarter (25%) supporting senior care home staff to do this (Table 2).

When GPs would consider completing an ECTP was primarily influenced by the patient's health state; 97% would consider completing a form if they felt the patient had a life expectancy of less than one year, 86% when a patient has been diagnosed with a life-threatening condition, and 71% when a patient entered a care home. Just one in four (24%) GPs would consider completing a plan based on the patient's age alone. An ECTP was considered by fewer respondents for people who were severely disabled (59%) or living with a long-term condition (61%) (Table 2).

A mixed pattern was seen for when GPs might consider reviewing ECTPs. Strikingly, one in five (20%) respondents reported that their practices had no system for reviewing forms. Only a minority had routine systems in place for reviewing these; annually (37%), six-monthly (12%), or at over 75s annual health check (28%). Even when there was a patient request (57%), or a change in health state (71%) it was far from standard practice to review forms. Only half (46%) would consider reviewing an ECTP following a hospital admission (Table 2).

Overall, ECTP was viewed positively; 89% agreed that having a plan ensures treating clinicians know the patient's wishes, 82% agreed it can avoid patient's families making difficult decisions. Nevertheless, half (51%) agreed that a patient's current health condition may not be reflected in the plan when implemented and there is a serious risk it could be out of date (Table 3).

Considering the last time they had completed an ECTP, a small minority (9%) reported that a family member was not involved. Most commonly this was because the patient had capacity 54/72 (75%),



although 18 (25%) reported that the family was not available and 11 (15%) that the patient didn't want the family involved. One respondent reported that the family did not want to be involved. (Table S2).

GPs reported being at least fairly comfortable having ECTP conversations with both the patient (81%) and the patient's family (79%) (Table 4).

In our adjusted logistic regression analyses for conversations with patients, locum and salaried GPs were substantially (around 48%) less likely to be comfortable having ECTP conversations compared to partner/principal GPs; OR=0.51 (95% CI 0.31 to 0.82) and 0.53 (95% CI 0.34 to 0.82) respectively (Table 5, Table S3). For conversations with family members the difference was only statistically significant for salaried GPs; OR 0.58, (95% CI 0.38 to 0.88) (Table S4).

When compared to London, GPs in the South-West and the North-East were substantially more likely (around 4.2 times more odds) to be comfortable with ECTP conversations; OR=4.30 (95% CI 1.45 to 12.7) and 4.10 (95% 1.22 to 13.8) respectively. For conversations with family members. GPs from the South-East, East Midlands, or Yorkshire and Humber were also more comfortable than GPs from London (Table 5).

GPs using a ReSPECT form were more comfortable having these conversations with patients (72% more odds) and family members (85% more odds) when compared to GPs using a DNACPR form; OR=1.72 (95% CI 1.1 to 2.69) and OR=1.85 (95% CI 1.19 to 2.87) respectively. Results from our sensitivity analysis using a backwards elimination model were not materially different (Tables S5 & S6)

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## Discussion

### Summary

This study shows that ECTPs have become a standard part of general practice with 100% of respondents reporting using some form of ECTP. Nevertheless, that just over half of our respondents are still using stand-alone DNACPR forms is potentially a cause for concern, when the limitations of DNACPR for making holistic patient centred decisions have been recognised since at least 2016.(17)

GPs who used ReSPECT when compared to DNACPR were more likely to feel comfortable in having ECTP conversations with patients and their relatives. The main trigger for initiating an ECTP conversation is diagnosis of a life limiting or life-threatening condition. Whilst completion of an ECTP in primary care is currently carried out predominantly by GPs, respondents suggested that this could be carried out by a much broader range of health and social care professionals.

Respondents were very supportive of a wider spectrum of health and social care professionals being able to complete ECTPs. Support for specialist nurse practitioners for palliative care completing these forms is not surprising. That a substantial minority (25%) of GPs support senior care home staff completing ECTP forms is perhaps more surprising as these are not designed for completion by non-clinicians. Possibly our respondents had in mind senior care home staff having the initial conversations with their residents rather than formal completion of the form without clinician input. Indeed, an interview study of GPs and care home staff found that GPs value the input of care home staff in ReSPECT conversations.(18) Whilst care home staff were generally positive about being involved, they had concerns about taking responsibility for the form's content.(18).

Most respondents report the patient's clinical condition as the stimulus for initiating ECTP conversations, predominantly in the context of life limiting diagnosis or terminal prognosis. This conceptualises ECTPs as being associated with end-of-life care. This contrasts with how its developers envisaged ReSPECT but is consistent with the previous studies of the ReSPECT process.(12, 19, 20). It is unclear whether time constrains the GP staff to focus on patients who are perceived to be likely to have an acute need for emergency care in the foreseeable future, or they are conflating ECTPs with advance care planning. How GPs conceptualise ECTPs may affect their views on who can complete them and how often they need reviewing. We are exploring this question in our related qualitative study.(15)

That one in five (20%) practices have no system for reviewing ECTPs with only 58% having any routine system for review is of concern, particularly since 41% of our respondents agreed that there might be a

serious risk of the plan being out of date and not reflecting the patient's views and half (50%) felt the patient's current health condition might not be reflected in the plan when implemented.

Caution is needed when interpreting the apparent regional differences observed in how comfortable GPs feel in having ECTP conversations because of the large number of comparisons and small numbers in some groups. Nevertheless, there appear to be differences between London, and the South West and the North East. This might reflect the impact of the presence/absence of local ECTP initiatives. For example, few London GPs use ReSPECT forms and will not have been exposed to ReSPECT training whilst in the North East there has been a long standing regional integrated approach to making care decisions in advance that includes emergency care treatment planning, with an associated education initiative (Table S1).(5)

That our data show that GPs using the ReSPECT forms are more comfortable with ECTP conversations is an important finding. What we do not know from this study is why they feel more comfortable and whether this increased comfort reflects the structure of the form itself, the added value of any training related to its implementation, of whether early adopters were already more comfortable. We do not know if this translates into better quality decisions or improved patient outcomes.

#### *Strengths and limitations*

We obtained a high-quality dataset with no missing data. Our respondents were representative of England in terms of region, age, practice size, years since qualification and region (Table 1). Nevertheless, outsourcing data collection to a market research company working through a commercially funded, free to use, website may have introduced bias into the sample selection. GPs signed up to the on-line survey with the Doctors.net.uk website may not be representative of all GPs in terms of their commitment to CPD and up to date practise. We do not know if we have had responses from multiple GPs working in the same practice. Females and non-principals were underrepresented in this survey. This needs to be set against the known challenges of sending 'cold' surveys to GPs in terms of response rate and data quality (Appendix 2). Some caution is needed interpreting regression analyses because of the large number of comparisons made. Given that many GPs are using DNACPR forms rather than ReSPECT (or other ECTP) forms it is possible some reflect their experiences of DNACPR decision making rather than emergency care and treatment planning Overall, our approach has delivered a robust overview of GPs' views on this difficult topic. Nevertheless, we have no data on what actually happens in general practice.

#### *Comparison with existing literature*

This is the first survey of GPs' use of ECTP.

#### *Implications for practice*



#### Ethical review

Ethical review was provided by London South East Research Ethics Committee (ref 21/LO/0455)

#### Competing Interests

MU, JD, FG, RS, AS, are chief investigators or co-investigators on multiple research projects funded by NIHR

MU is a co-investigator on grants funded by the Australian NHMRC and Norwegian MRC. He was an NIHR Senior Investigator until March 2021. He is a director and shareholder of Clinvivo Ltd that provides electronic data collection for health services research. He receives some salary support from University Hospitals Coventry and Warwickshire He is a co-investigator on two current and one completed NIHR funded studies that have, or have had, additional support from Stryker Ltd

PG is supported by NIHR Applied Research Collaboration West Midlands and is an NIHR Senior Investigator.

#### Role of the funder

This work was funded UK National Institute for Health Research (NIHR131316). The funder of the study had no role in study design, data collection, data analysis, data interpretation or writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

The views expressed in this publication are those of the authors and not necessarily those of the NIHR or the UK Department of Health and Social Care.

#### Data sharing

All requests for data should be sent to the Warwick Clinical Trials Unit data access team ([wctudataaccess@warwick.ac.uk](mailto:wctudataaccess@warwick.ac.uk)). Access to anonymised data may be granted following review.

**Table 1**  
**Respondent characteristics, totals, and percentages**

	Total (N=841)		National data
<i>Age</i>			
	35 or under	39	5%
	36 to 45	319	38%
	46 to 55	318	38%
	56 or over	165	20%
<i>Gender</i>			
	Male	446	53%
	Female	385	46%
	Other	1	0%
	Prefer Not to Say	9	1%
<i>Current role</i>			
	GP Partner / Principal	419	50%
	Salaried GP	255	30%
	Locum GP	156	19%
	GP Registrar	11	1%
<i>English NHS Region</i>			
	London	114	14%
	South West	85	10%
	South East	142	17%
	West Midlands	92	11%
	East Midlands	62	7%
	East of England	93	11%
	Yorkshire and Humber	94	11%
	North East	44	5%
	North West	115	14%
<i>Type of area</i>			
	Major Conurbation	157	19%
	Large Town/City	124	15%
	Medium Town/City	207	25%
	Small Town/City	254	30%
	Hamlet	94	11%
	Other	5	1%
<i>Practice size</i>			
	Up to 5,000	89	11%
	5,001-7,500	129	15%
	7,501-10,000	181	22%
	10,001-12,500	147	17%
	12,501 or more	295	35%
<i>Time since completing GP training</i>			
	0-5 years ago	51	6%
	6-10 years ago	140	17%
	11-15 years ago	225	27%
	16-20 years ago	160	19%
	Over 20 years ago	265	32%

a) Data from <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services>, age bands not exact matches, 1% unknown, excludes trainees

b) Data from <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services>, other includes unknown, excludes trainees & locums

c) Data from <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services>

[medical-services](#), denominator all GPs, Locum and trainees not reported because of difference in definitions

- d) Population distribution as proxy for GP practice location from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1028819/Rural\\_population\\_Oct\\_2021.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1028819/Rural_population_Oct_2021.pdf)
- e) data from <https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/february-2023>
- f) Data from <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services>, other includes unknown, excludes trainees & locums
- g) No suitable data source identified

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**Table 2**

**Totals and percentages for the emergency care and treatment planning form completion**

	Total (N=841)	% (95% CI)
<i>What form of Emergency Care and Treatment plans does your practice use?</i>		
ReSPECT	345	41 (38, 44)
DNACPR	426	51 (47, 54)
Other	70	8 (6, 10)
<i>Who completes Emergency Care and Treatment Plans within your practice?</i>		
GP	780	93 (91, 94)
GP Trainee	0	-
Practice nurse	79	9 (7, 11)
Advanced nurse practitioner	234	28 (25, 31)
Specialist nurse practitioner for elderly care	140	17 (14, 19)
<i>Who do you think should be able to complete Emergency Care Treatment Plans in a GP practice?</i>		
GP	797	95 (93, 96)
GP Trainee	522	62 (59, 65)
Practice nurse	350	42 (38, 45)
Advanced nurse practitioner	648	77 (74, 80)
Specialist nurse practitioner for elderly care	663	79 (76, 82)
Emergency Care Practitioner	550	65 (62, 69)
<i>Who do you think should be able to complete Emergency Care Treatment Plans in the community?</i>		
Specialist nurse practitioner for palliative care	802	95 (94, 97)
Other specialist nurse practitioner	691	82 (80, 85)
Community matron/senior nurse practitioner for community care	690	82 (79, 85)
District nurse	467	56 (52, 59)
Senior care home staff	207	25 (22, 28)
Senior nurses in nursing home	430	51 (48, 55)
<i>When would you consider completing an Emergency Care and Treatment Plan for a patient?</i>		
When a patient reaches a certain age	199	24 (21, 27)
When a patient is diagnosed with a life-threatening condition	722	86 (83, 88)
When a patient is diagnosed with a chronic long-term condition	509	61 (57, 64)
When a patient is severely disabled	497	59 (56, 62)
When you think a patient is likely to die within 12 months	813	97 (95, 98)
When a patient is admitted to a care home	596	71 (68, 74)
<i>When do you review an Emergency Care and Treatment Plan for a patient?</i>		
When a patient requests it	477	57 (53, 60)
When a patient is discharged from hospital with an ECTP	389	46 (43, 50)
Annually	309	37 (33, 40)
Six-monthly	104	12 (10, 15)
Annually, or six monthly, or a >75 health check	486	58 (54, 61)
During or following the annual health check for patients aged 75 or over	238	28 (25, 31)
When you think the patient's health has changed	595	71 (68, 74)
My practice does not have a system for reviewing ECTP forms	169	20 (17, 23)



**Table 3**  
**Attitudes to Emergency care treatment planning**  
 (N=841)

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly agree
<i>Having a plan means that the patient might not get a treatment that could save their life</i>	14 2%	128 15%	131 16%	375 45%	193 23%
<i>Having a plan can avoid the patient's family having to make difficult decisions for them</i>	200 24%	489 58%	104 12%	38 5%	10 1%
<i>There is a serious risk that the plan could be out of date when implemented and not reflect the patient's current views</i>	33 4%	315 37%	277 33%	200 24%	16 2%
<i>The patient's current health condition may not be reflected in the plan when implemented and there is a serious risk it could be out of date</i>	34 4%	391 46%	235 28%	166 20%	15 2%
<i>Having a plan ensures that treating clinicians know the patient's wishes</i>	224 27%	527 63%	80 10%	9 1%	1 0%

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**Table 5**  
**Odds ratios (95% CIs) and p-values of the predictors for being comfortable having emergency care and treatment planning conversations with patients**  
**(N=841)**

	Comfortable (n)	Odds ratio (95% CI)	P value
<i>Gender</i>			
Female	81% (385)	1	
Male	81% (446)	0.85 (0.59, 1.24)	0.407
Other	100% (1)	-	0.995
Prefer not to say	67% (9)	0.36 (0.08, 1.53)	0.166
<i>Current role</i>			
GP	85% (419)	1	
Partner/Principal	100% (11)	-	0.984
Locum GP	73% (156)	0.51 (0.31, 0.82)	0.006
Salaried GP	77% (255)	0.53 (0.34, 0.82)	0.004*
<i>NHS region</i>			
London	69% (114)	1	
East of England	77% (93)	1.24 (0.49, 3.15)	0.655
West Midlands	78% (92)	1.29 (0.53, 3.16)	0.577
North West	77% (115)	1.54 (0.68, 3.49)	0.297
Yorkshire and Humber	83% (94)	1.80 (0.70, 4.63)	0.222
South East	83% (142)	2.08 (0.84, 5.17)	0.115
East Midlands	89% (62)	2.47 (0.78, 7.86)	0.124
North East	89% (44)	4.10 (1.22, 13.8)	0.023
South West	91% (85)	4.30 (1.45, 12.7)	0.008
<i>Type of area</i>			
Large Town/City	84% (124)	1	
Major Conurbation	74% (157)	1.01 (0.43, 2.35)	0.987
Medium Town/City	80% (207)	0.75 (0.40, 1.40)	0.361
Small Town/City	83% (254)	0.76 (0.41, 1.41)	0.391
Village/Hamlet	85% (94)	1.16 (0.53, 2.54)	0.714
Other	60% (5)	0.30 (0.04, 2.22)	0.237
<i>Practice size</i>			
Up to 5, 000	75% (89)	1	0
5, 001-7, 500	78% (129)	0.98 (0.49, 1.96)	0.961
7, 501-10, 000	76% (181)	0.85 (0.44, 1.62)	0.614
10, 001-12, 500	83% (147)	1.40 (0.68, 2.86)	0.360
12, 501 or more	85% (295)	1.60 (0.83, 3.11)	0.161
<i>Time since completion of GP training</i>			
0-5 years ago	90% (51)	1	
6-10 years ago	83% (140)	0.62 (0.21, 1.82)	0.388
11-15 years ago	81% (225)	0.54 (0.19, 1.52)	0.246
16-20 years ago	80% (160)	0.46 (0.16, 1.35)	0.158
Over 20 years ago	78% (265)	0.43 (0.15, 1.19)	0.105
<i>Emergency care and treatment form used</i>			
DNACPR	77% (426)	1	
ReSPECT	86% (345)	1.72 (1.10, 2.69)	0.017
Other	80% (70)	1.00 (0.51, 1.95)	0.998

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