

## End of life and escalation discussions

Remember that all of these stations are based around communication. The conversations should be had in an appropriate setting and should not be interrupted by bleeps etc. Find out what the patient/family know first and try to gauge their understanding. Ensure you are empathetic, chunk-and-check and make use of pauses. Don't forget to listen to the patients/relatives **ideas, concerns and expectations**.

### Discuss do not attempt cardiopulmonary resuscitation (DNACPR) discussions

#### Background information

- Resuscitation is ultimately the **medical teams decision** (a patient can refuse it but cannot demand it)
- Success of in-hospital resuscitation is around 20%; this may be much lower if there are comorbidities/reasons why it is less likely to be successful. Of the people who survive resuscitation, only around half will make it out of hospital.
- A DNAR form may be completed for one of three reasons:
  - Resuscitation is unlikely to be successful
  - The patient does not want it
  - It may be successful but will result in a quality of life that is unacceptable to the patient
- If a patient has capacity, they should be informed of the decision (unless it will cause significant physical or psychological harm)
- If a patient does not have capacity, the relatives of the patient should be informed
- All DNAR discussions should be clearly documented
- 'Do Not Resuscitate' does not mean stop treatment
- If the form is signed by a junior doctor, it should be countersigned by a consultant as soon as possible

#### Approach

- It is usually best brought up during a wider discussion about advance care planning
- Work your way up to it rather than jumping in to talking about resuscitation – build a rapport first and start by talking about the current problems and the treatments that are being given
- Explain there is a risk things may get worse and the patient may deteriorate
- Explain to them about resuscitation, what it involves
- If CPR would not be successful, sensitively explain why the team feel it would not be appropriate; when there is a possibility it may be successful, discuss their wishes and feelings and try to determine whether the benefits would be greater than the risks and burdens and if the level of recovery would be acceptable to the patient
- Stress that it does not mean that the patient will not be treated – the form only matters if their heart stops
- Do not ask the patient or relatives to make the decision
- If the patient/relatives strongly disagree, don't force it – escalate the discussion to your seniors or ask for a second opinion

#### Phrases to help

- One thing that it is important for us to talk about is resuscitation
- You are very unwell at the moment and we need to talk about what we would do if you were to get worse despite treatment
- We feel it would be kinder and more appropriate to ensure he is not in any pain or distress in the last moments of his life. If it were to get to the point where his heart were to stop, we would not try to restart it.
- We will still give her every treatment available on the ward, the form just means that if she were to become much more unwell and reach the natural end of her life, we would not do chest compressions and shocks to restart it, because this can cause a lot of pain and distress and prolong suffering
- Eventually, his medical condition will mean he will, at some point, get to the natural end of his life and it is important we talk about this before it happens – trying to restart the heart in this situation would not be the right thing to do
- We only have one chance at end of life care so we want to get it right
- Even if a patient survives resuscitation, they are often more disabled after and left with a quality of life that they would not want

### Other treatment escalation decisions

- In addition to decisions regarding resuscitation, decisions should also be made about other invasive treatments where appropriate – these should be documented in the patients notes and on a treatment escalation plan document
- The patient can only insist upon things that they **do not** want
- It is for doctors to decide which treatments are appropriate and should be offered and which treatments are not appropriate e.g. intensive care admission, non-invasive ventilation, parenteral nutrition etc.
- Factors to take into account when considering intensive care admission include:
  - **Diagnosis, severity of illness and prognosis:** a patient must have an acute reversible condition to warrant intensive care treatment and there must be treatment available to treat it
  - **Age, comorbidities and physiological reserve:** surviving intensive care and invasive treatment requires a good physiological reserve (e.g. there would be no point ventilating patients who will not be able to get off the ventilator)
  - **Anticipated quality of life:** there is often a physiological decline after severe illness and it is important to consider if the patient would be left with a quality of life they feel is worth living
  - **Patient wishes:** if a patient does not want invasive treatments, then their choice should be respected (if the patient cannot communicate this, it is important to speak to their family about what their wishes would have been)

## ***Explain to relatives a patient is at end of life***

### Approach

- Use a breaking bad news approach (*see notes on breaking bad news*)
- Explain to the family you will involve the palliative care team if required, and offer religious input where available e.g. chaplain
- Ensure you talk about the patient's symptoms and reassure them that they can be managed

### Phrases to help

- We have tried giving strong antibiotics, fluids and oxygen but he has not made any improvement at all – PAUSE
- I am afraid, he is not going to recover from this and he is now in final stages of his life – PAUSE
- We believe further invasive treatment and tests will prolong his suffering and will not make any difference
- The most important thing now is for us to concentrate all our efforts to make sure he is comfortable and not in any pain or distress

## ***Consent for post mortem***

### Background information

- Types and refusal
  - **Coroner's post mortem:** the relatives cannot decline it (it must be carried out by law)
  - **Consented post mortem** (for educational purposes): written consent required from next of kin
- A consented post mortem is usually done so doctors can learn what happened to better manage other patients in the future
- It is done in a respectful manner
- Incisions will be hidden by clothes/hair
- All tissue will be replaced inside the body unless required by coroner or specified on consent form
- It takes around 3 hours
- It is usually done within 2-3 days so funerals do not need to be delayed
- The report will be sent to the coroner/consultant and the GP – the relatives can meet with them to discuss the results because it will contain medical terminology

### Approach

- Be respectful and always start by saying you are so sorry for their loss
- Ask them how much they know about what happened and what caused their death
- Coroners post mortem: explain that when it is not clear what his happened, we have to speak to the coroner and that in some circumstances they order a post mortem (remember you may be breaking bad news)
- Explain why it is necessary – it is important to learn what caused their death so that the medical team can learn what happened to help future patients
- Find out what their concerns about post mortem are – they may not understand or have misconceptions about what is involved

## ***Brainstem death***

### Background information

- Brainstem death = irreversible loss of all brain and brainstem function
- It is confirmed by two qualified specialists who do a series of tests independently that look at brainstem reflexes and breathing

### Approach

- Use a breaking bad news approach
- Explain the patient is dead, despite the machine making it look like they are still breathing
- Explain that two senior consultants have done multiple tests to confirm the patient is dead
- Explain that we should now turn off the ventilator

## ***Organ donation***

### Background information

- Donation may occur in three ways: after brainstem death, after circulatory death or as a living donor
- Patients cannot donate if they have HIV, CJD or metastatic cancer
- Consent can be from the patient or relative
- If a patient has clearly consented before death, the relatives do not have the legal right to override the decision
- If a patient has not consented before death, consent from relatives is required

### Approach

- Explain what organ donation involves
- Explain the benefits
- Reassure relatives about funerals and the fairness of organ allocation
- If the patient has not expressed a wish to donate, find out what they would have wanted