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AGENDA

Right to life does not depend on age or disability

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THERE has been confusion and concern in recent days about whether doctors and nurses should have discussions with patients and their families, about whether they should have CPR (cardio-pulmonary resuscitation) in the event of them becoming seriously ill with Covid-19.

DNACPR (do not attempt cardio-pulmonary resuscitation) forms are sometimes agreed upon with patients, normally when they are very frail or have a terminal condition. It is part of carrying out Anticipatory Care Planning with our patients, which is being done all the time. DNACPR forms are valuable to prevent unnecessary and distressing CPR being carried out. Ambulance crews are obliged to carry out CPR for a prolonged period if they are called to a patient with cardiac arrest and there is no DNACPR form.

Health workers are now being advised to have discussions with their more vulnerable patients in the community to ask them if they would like CPR performed in the event of them contracting the virus. This includes those within the health board I work for. If it is agreed to have a DNACPR form signed, the information is normally uploaded to a Key Information Summary on the GP's computer which is then also visible to ambulance and hospital clinicians who may be seeing the patient for the first time.

There are a number of problems with having these CPR discussions in the community right now. First, they may put pressure on the patient to agree to a DNACPR decision in a time of uncertainty and anxiety. Decisions may then be made hastily that are not based on good evidence.

Secondly, though most health workers would conduct such discussions sensitively, the patient may sometimes receive the impression that they are not as valuable as others or as a worthy as others to receive CPR. This could harm the relationship that a GP or nurse has with his or her patients.

> "There are problems with having these discussions right now

Thirdly, such decisions are normally made, with a small number of patients, regardless of Covid-19 infection. It is strange to assume that acquiring the infection would suddenly change the status of the patient regarding resuscitation.

Fourthly, if such a patient then falls ill and suffers cardiac arrest, this may be due to something entirely separate from Covid-19. He or she should have the normal CPR when considered appropriate by the clinical team at the time.

Fifthly, any such patient who becomes gravely ill with Covid-19 will have decisions, including performing CPR, made by the clinicians (where possible with discussion with the patient and family), based upon the condition of the patient right then. We cannot predict this in advance.

Finally, some of this is driven by worry that resources in hospital intensive care units will become overwhelmed. It could indeed become very difficult for clinicians to decide who should get priority care in these circumstances. But such decisions, while very difficult, should be separate from making a CPR decision now in the community. The clinicians in the hospital have access to the Key Information Summary made by GPs on vulnerable patients to help them make the right decisions.

There could be a danger here of categorising patients into those who are worth resuscitating and those less deserving of it as human beings. All our patients are humans of equal worth, and our right to life does not depend on age, disability or any other criteria.

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