Briefing from RCGPNI to Stormont Health Committee Evidence Session 16 April 2020.

The RCGP is a membership body of over 53,000 GPs in the UK, which was established to encourage, foster and maintain the highest possible standards in general practice. In Northern Ireland the RCGPNI represents over 1400 GPs, around 80% of the workforce.

We support Minister Swann, Department of Health and the CMOs efforts to manage the effects of the Covid-19 pandemic, as well as all of those involved in the national effort and wish to update the committee on the important issue of Advance (or Anticipatory) Care Planning (ACP.)

The key issues around ACP for RCGPNI are:

1. Advance Care Planning must be part of a National Conversation.
2. Discussions about Advance or Anticipatory Care Planning (ACP) are sensitive and must ensure the patient and their family are at its heart. Cardiopulmonary Resuscitation (CPR) is not a treatment and when included in discussions frequently becomes an unhelpful distraction. We suggest there should be no requirement for CPR discussion to be a mandatory part of ACP and it should only be raised if felt by patients or the healthcare professional to have benefit
3. ACPs should be done not only by GPs but by the health care professional best known and trusted by the patient.

The 2010 DoH paper: Living Matters Dying Matters highlights the need for families and the public to discuss end of life care. (1.)

“...discussion about palliative and end of life care should be promoted and encouraged through media, education and awareness programmes aimed at the public and the health and social care sector.”

The current Covid-19 pandemic has seen the importance of these discussions elevated. A patient with marked frailty, numerous medical conditions (multi-morbidity) and general poor health will statistically be less likely to benefit from aggressive medical intervention and escalation of care.

GPs and other health care workers recognise their duty to have these conversations, but we urge Department of Health to initiate the discussion at a national level. If left to health professionals these discussions risk us being viewed as rationers of care rather than the patient advocates we pride ourselves to be.

1.) RCGPNI urges Department of Health to publicly encourage society and families to “Have the Chat” with other family members who are frail and in poor health.

For years GPs in Northern Ireland have been having sensitive and person-centred conversations with patients about what is important to them and what their wishes are if their medical condition worsens. During these times, GPs have discussed with their patients, potential scenarios and options for consideration.
Frequently, when advised of the various options, patients choose to have their care provided in their own homes or care homes supported by excellent care from GPs, district nurses and Macmillan and Marie Curie nurses.

Our experience of Covid-19 has shown a somewhat different disease trajectory than the usual slow gradual decline of frailty or cancer. Patients often develop sudden respiratory difficulties such that urgent choices about clinical care need to be made. Such circumstances are far from the ideal setting for these important decisions. It is much more desirable that a patient has had the opportunity before becoming acutely unwell to reflect and chat with loved ones about the level of medical care they would wish if the worst happened. ACPs provide an individualised, “thinking ahead” philosophy that significantly help when difficult decisions are required.

Access to good quality palliative medicines and personal care in these times are vital and we urge families to concentrate on these issues which optimise quality of life in familiar environments rather than hospital care where during the current Covid-19 crisis, visiting from families is currently restricted.

We urge Department of Health to initiate this as a national discussion and not to rely on health professionals “cold calling” patients. If patients have initial warning about the impending discussion it will not come as a surprise and can allow for families to have discussion about “what is important to me.”

2.) RCGPNI Urges the issue of resuscitation (DNACPR) to be omitted as obligatory from Advance Care Planning unless specifically requested by patients or professionals. Advance Care Planning is about ensuring a person and their family are at the heart of difficult end of life conversations and what is important to them.

The issue of advanced “Do Not Resuscitate” orders (DNACPR) has been unhelpful to ACP for years. CPR does not reverse underlying conditions. It will be unsuccessful if a patient has an advanced illness. Similarly, if a frail patient with poor underlying health conditions suffers a cardiac arrest, the chances of successfully regaining circulation and restoration to health is very small whereas the likelihood of harm, is very high The process of CPR has been glamorised by Hollywood films, but patients who undergo CPR, risk underutilising palliative medication and having the opportunity to spend their remaining days with family and loved ones.

Unfortunately, DNACPR has been misinterpreted as refusing patients treatment or access to basic care. It has even been misinterpreted as rationing. It is not. No other treatments or interventions are excluded by this decision and some, or all, may or may not be suitable, depending on an individual patient’s circumstances.

Covid-19 raises new issues with CPR. All first responders are taught well to remove any danger to themselves or others when arriving at the scene and the Resuscitation UK guidance states: (3)

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<th>SAFETY</th>
<th>Make sure you, the victim and any bystanders are safe</th>
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Subsequent resuscitation guidance recommends that all chest compression and efforts to perform should avoid mouth to mouth and only use chest compressions. It advocates full use of PPE to be escalated to levels which protect from Aerosol Generating Particles (AGPs) which would include gowns and FFP3 masks. (4)

Frail patients who have Covid 19 or are at significant risk of having Covid-19 are unlikely to recover from cardiac arrest and in one study from Wuhan Chain showed that of 136 patients suffering cardiac arrest due to Covid-19, only one recovered with a favourable neurological outcome after 30 days. (5)

A joint statement from RCGP, BMA, CQC suggests that it is inappropriate to apply DNACPR decisions to any group of people and these need to be done on individual basis. RCGP and BMA all support this position and encourage the sensitive and individual discussion on what is in a patient’s best interest. (6)

During the Covid-19 crisis we would like the Department of Health to reassure clinicians that there is no specific requirement to have a DNACPR discussion as part of ACP, unless the patient raises this and wishes to discuss it, or the clinician feels strongly that it needs to be included. Instead the focus
should be on supportive discussions with patients about what matters to them should they fall ill with Covid.

3.) ACPs should be performed by a wide range of health professionals and not just GPs

We believe the clinician who best knows the patient should discuss the Advance Care Plan with the patient and ideally also their family, if appropriate. This should also include suitably trained healthcare professionals such as care home staff, Macmillan and Marie Curie nursing staff. Many patients with long term chronic conditions are better known by their hospital doctor and where possible the discussion should be easily conveyed with electronic communication methods. Between primary and secondary care. Currently there is a discrepancy over DNACPR directives. If a patient or their family have opted not to avail of resuscitation in hospital (DNACPR), this directive is not being recognised in community. This risks the important wishes of patients and families being lost to unnecessary communication barriers.

RCGP has extensive resource available to all GPs for free throughout the Covid-19 crisis. They include extensive educational materials on relevant topics such as communication, advanced care planning and ethics. (7.)

On Advance Care Planning, RCGP advises:

“The principle underlying these conversations is to establish and respect the autonomous preferences of patients, who are often vulnerable, on the types of care they would like to receive in the event of getting infected with COVID-19, or any other serious or life-threatening illness.” (8)

Hospital Physicians like Dr Courtney, Surgeons like Mr Taylor and GPs like myself have all dedicated our professional working lives to advocate for our patients. We will not advise them on a treatment or path that we feel is not in their best interests. We will always strive to offer them the highest standards of care available but in difficult circumstances, such as with Covid-19, good personal care with access to palliative support is frequently best for our patients.

ACP is not a one-off discussion but should be an ongoing discussion with a patient and their family and can change according to a patient’s clinical condition and personal circumstances. This discussion should not be limited to the current Covid crisis but constitutes good medicine and must be recognised as best practice by all doctors.

References:


3.) RESUS information https://www.resus.org.uk/resuscitation-guidelines/adult-basic-life-support-and-automated-external-defibrillation/#blsaed


5.) Academic article: In-hospital cardiac arrest outcomes among patients with COVID-19 pneumonia in Wuhan, China https://www.resuscitationjournal.com/article/S0300-9572(20)30142-8/pdf

6.) Joint statement on advance care planning RCGP, BMA and CQC https://content.govdelivery.com/accounts/UKCQC/bulletins/283e565

7.) https://elearning.rcgp.org.uk/course/view.php?id=373