Royal College of Physicians

Mythbusters

Cardiopulmonary resuscitation (CPR)

Many myths exist about care at the end of life that can add to the complexity of delivering care. In particular, there is much misunderstanding about cardiopulmonary resuscitation (CPR). Here we recount the main myths and provide responses that may be helpful for your own knowledge and in talking about dying with patients, carers, families and friends. These responses originally appeared in our 2018 report, *Talking about dying*.

If CPR may be successful but is likely to result in significant disability

30% of survivors of in-hospital cardiac arrest will be left with clinically significant neurological disability. However, where attempting CPR has a reasonable chance of successful return of spontaneous circulation for a sustained period and a person has decided that the quality of life that can reasonably be expected is acceptable to them, then their wish for CPR should be respected. A second opinion should be offered in cases of disagreement.

If CPR is unlikely to be successful

When a person is dying as an inevitable result of advanced, irreversible disease or a catastrophic event and there is no realistic prospect of a successful outcome, then CPR should not be attempted.

You can help patients and their loved ones to understand that:

- cardiorespiratory arrest is part of the final stage of dying
- CPR is unlikely to be successful when someone is dying from an advanced and irreversible or incurable illness
- healthcare professionals may start CPR inappropriately when someone dies unless a DNACPR (do not attempt cardiopulmonary resuscitation) decision has been made and recorded.

If the patient declines CPR

Patients can decide to refuse CPR even if the clinical team thinks that it might be of benefit. This should be discussed as a matter of routine when patients are admitted to hospital with a foreseeable (even if remote) risk of cardiac or respiratory arrest.

Communication of DNACPR decisions

Patients should be included in discussions about DNACPR. If explaining a DNACPR decision will impose such distress that the patient suffers harm, then the reasons for not involving them must be documented fully.

When to involve family

With the patient's consent, it is best practice to involve the patient's loved ones in conversations about CPR.

If the patient does not have mental capacity, then every effort must be made to contact a legal proxy or those close to them. Staff must attempt to inform those close to the patient of a DNACPR decision, even it if it may be inconvenient or undesirable at a particular time. However, if attempts to make contact have failed, the decision should not be delayed inappropriately and the senior clinician should:

- record fully their reasons for not explaining the decision to those close to the patient at that time
- ensure that there is ongoing active review of the decision
- ensure that those close to the patient are informed at the earliest practical and appropriate opportunity.

If the patient does not have a legal proxy with relevant authority, those close to the patient have an important role in advising the healthcare team about the patient. However, it is not their responsibility to decide whether CPR will be of overall benefit.

‘Patients with a DNACPR won’t receive other treatments as a priority’

Patients with DNACPR orders can, do and should receive other active treatments as appropriate. DNACPR is not synonymous with stopping treatment. An emergency call can be put out for a patient with a DNACPR order if they are unwell and you need help urgently.

‘CPR will always save a life’

When a person is in the final stages of an incurable illness and death is expected within a few hours or days, in almost all cases CPR will not be successful. CPR cannot reverse the person’s underlying condition and it may prolong or increase suffering. Average survival to discharge after in-hospital cardiac arrest is 15–20%, but long-term cognitive impairments are present in half of these survivors. Average survival to discharge after out-of-hospital cardiac arrest is lower, at 5–10%. In non-shockable rhythms or when the arrest is not witnessed, it is <10%.

‘Families or patients can demand CPR even if it will be futile’

CPR remains a clinical decision, and physicians are not required to offer interventions that are futile or inappropriate.

‘Whether to have CPR is the most important decision in advance care planning’

For most people, CPR is completely irrelevant and other decisions are much more important, such as which disease-related treatments to accept. Increasingly, healthcare organisations are using the ReSPECT process to record wider emergency care wishes and recommendations, including CPR decisions.

‘DNACPR forms are legally binding’

DNACPR forms are not legally binding. Occasionally, a person for whom a DNACPR decision has been made may develop cardiac or respiratory arrest from a readily reversible cause, eg choking. In such situations, CPR could be appropriate while the reversible cause is treated, unless the person has made a valid refusal of the intervention in those specific circumstances.

More information

For more information about end of life care, please visit www.rcplondon.ac.uk/projects/outputs/talking-about-dying-2021-how-begin-honest-conversations-about-what-lies-ahead. There you can also find our full *Talking about dying report* (2018), which includes references. If you have any questions or comments, please contact us via policy@rcp.ac.uk.