

Q&A on DNACPR

1. **Why is the term DNACPR used instead of DNR?**

Do Not Resuscitate (**DNR**), Do Not Attempt Resuscitation (**DNAR**), and Do Not Attempt Cardiopulmonary Resuscitation (**DNACPR**) all refer to the same decision that CPR is not to be initiated on the patient, based on prior deliberations between the patient/family and the healthcare team. This set of guidelines promulgated since 2014 have chosen to adopt the full descriptive name, DNACPR, so as to emphasize that the plan is strictly referring to the treatment option of CPR only, and does not automatically imply whether the patient will or will not be receiving other life-sustaining treatments. DNACPR is also the term used in relevant documents of NHS and GMC of UK.

2. **What has been added to this set of Guidelines since 2014 compared to the last set of Guidelines of 1998?**

Refinement on the practice on DNACPR for hospitalized patients, including:

- (a) Standardization of the DNACPR form for hospitalized patients,
- (b) The general requirement of a specialist in the DNACPR decision (see questions 3 and 4 below), and
- (c) The mandatory requirement to involve at least two doctors, one being a specialist, in the DNACPR decision for a mentally incompetent patient who has no family members.

Addition of a set of guidelines on DNACPR decision-making for seriously ill non-hospitalized patients, with the following essential features:

- (a) Standardization of the DNACPR form for non-hospitalized patients,
- (b) The mandatory requirement of at least two doctors, one being a specialist, in the DNACPR decision,
- (c) Restricting the use of the DNACPR form (for non-hospitalized patients) to special categories of seriously ill patients with an AD, and special categories of seriously ill patients with an explicit ACP (Section 9.1.2).

3. **Is phone endorsement by a specialist adequate for a DNACPR order for a hospitalized patient?**

Assuming that a doctor of any grade has been at the bedside assessing the patient and exploring treatment options with the patient/family, and has come to the DNACPR decision, the order can be written into the DNACPR form and signed by the on-site doctor, who could be a specialist him/herself, or who will have ascertained the endorsement of the DNACPR decision by a specialist who may be on site or off site. In the situation that the specialist is off site, a verbal endorsement of the DNACPR order over the phone is acceptable as long as the verbal endorsement is signed by the specialist afterwards at the earliest possible time. Proper documentation by the on-site doctor of the specialist's verbal endorsement is required on the DNACPR form.

4. **Under what circumstances can the on-site doctor, who is not a specialist, sign a DNACPR order, without specialist endorsement, for a hospitalized patient?**

When the hospitalized patient is already holding a valid DNACPR form for non-hospitalized patients, one non-specialist doctor can continue to respect this form and

may sign a DNACPR order in the hospital without specialist endorsement. The presence of the valid DNACPR form for non-hospitalized patients should be documented on the DNACPR order for hospitalized patients. Caution must be taken to ensure that the AD or ACP remains valid and unchanged, and the current clinical condition falls within the circumstances under the patient's AD or ACP (Section 11.2.4).

For patients transferred from one hospital to another with an in-patient DNACPR order, a decision to continue the in-patient DNACPR order may be made by one non-specialist doctor in the receiving hospital if this is considered appropriate (Section 11.2.5).

5. Why is there a category of “other end-stage irreversible life limiting condition” at Section 9.1.2.1 for non-hospitalized patients with AD?

Although the scope of the model AD form proposed by the Law Reform Commission of Hong Kong in 2006 is limited to terminal illness, persistent vegetative state and irreversible coma, common law in Hong Kong does not restrict AD to these three conditions. A patient may sign an AD refusing life sustaining treatment (including CPR) if suffering from other end-stage irreversible life limiting conditions, e.g. chronic renal failure or chronic obstructive pulmonary disease (which may not be classified as a terminal illness because the survival may be prolonged by dialysis or assisted ventilation), or irreversible loss of major cerebral function and extremely poor functional status (which may not fall into persistent vegetative state or irreversible coma). With the inclusion of this category, the healthcare team may sign the DNACPR form (non-hospitalized patients) if such an AD is valid and the patient falls into the condition specified in the AD. However, if the AD refuses CPR in conditions which are not end-stage or not irreversible, e.g. simply for old age, the DNACPR form should NOT be signed.

6. Why is there a category of “other end-stage irreversible life limiting condition” at Section 9.1.2.2 for minors and incompetent adults without an AD?

This category includes those conditions explained in question 5. For minors, this category may include, for example, children with severe medical conditions such as mucopolysaccharidosis, mitochondrial disorder, Pompe disease etc, when they enter the end-stage of their disease. A competent adult with end-stage irreversible life limiting illnesses may sign an AD if he/she does not want CPR (please refer to question 5). However, a child or an incompetent adult cannot sign an AD. With the inclusion of this category, the healthcare team may sign the DNACPR form (non-hospitalized patients) if decision has been made with the parents/family through an ACP process that CPR is not in the best interests of the patient.

7. (a) What can one do if a mentally incompetent non-hospitalized patient does not belong to any categories at Section 9.1.2, but there is consensus among the healthcare team and the family that CPR is not in the best interests of the patient?

(b) What can one do if a mentally competent non-hospitalized patient with terminal illness or other end-stage irreversible life limiting illness refuses CPR, but does not want to sign an AD?

Under these two scenarios, there could be controversies regarding the suitability of recommending DNACPR in the non-hospitalized setting. These are outside the scope of the DNACPR form (non-hospitalized patients) and the form should NOT be signed. The original healthcare team may still consider to write a letter explaining the situation to the receiving healthcare team, and leave the final decision to the receiving healthcare team. If the original healthcare team decides to write a letter, the letter should be carefully worded, reflecting accurately the consensus of the original healthcare team and the family or the patient's refusal of CPR.

8. **Why does the healthcare team still have to sign the DNACPR form (non-hospitalized patients) when the patient already has signed an AD with a refusal of CPR?**

The DNACPR form assists the receiving health care team by telling the receiving healthcare team that the AD was validly made and the condition of the patient as presented to the original health care team falls within the AD. The receiving healthcare team may decide not to perform CPR if they are satisfied that the AD has not been revoked (i.e. DNACPR remains valid and unchanged), the condition of the patient as presented to them falls within the AD and no untoward event is suspected. The patient is advised to attach the AD to the DNACPR form (non-hospitalized patients). The receiving healthcare team, in addition to checking the DNACPR form, should do usual checking of the contents and inspection of the AD, e.g. name, date, the directive to refuse CPR, and any clear signs of revocation on the AD form.

9. **There is no legal requirement for the patient or family to sign when a doctor makes a DNACPR decision based on the patient's wish or the patient's best interests. Why do the guidelines recommend either an advance directive or signature of the family (for minors or incompetent adults without an AD) for a DNACPR decision for non-hospitalized patients?**

For non-hospitalized patients, the guidelines recommend either an AD or signature of the family (for minors or incompetent adults without an AD), because:

- (a) the non-hospitalized patients involve another clinical team, whereas the same clinical team is involved for the in-patient;
- (b) the immediate format of communication for the non-hospitalized patient is the DNACPR form only, whereas the full medical record is available for the in-patient.

Thus, an explicit documentation of the decision is preferred for the DNACPR form for non-hospitalized patients.

10. **When the Guidelines say that “before consensus is reached with a mentally competent adult or with the family of a mentally incompetent adult or a minor, a DNACPR decision should not be made in advance”, does this mean CPR must be done for an in-patient when consensus on DNACPR cannot be reached even though CPR is clearly not in the best interests of the patient?**

The Guidelines at section 7.7.8 say that “Normally, before consensus is reached with a mentally competent adult or with the family of a mentally incompetent adult or a minor, a DNACPR decision should not be made in advance.” This is to emphasize the importance of reaching consensus with the patient or the family. However, this does not mean that CPR must always be provided for an in-patient when consensus is not reached. The Guidelines state at section 2.4 that “no healthcare professional is obliged to provide medical treatment which is not in the best interests of the patient.” If CPR is clearly not in the best interests of the patient after due consideration of the values and preferences of the patient, but consensus for DNACPR cannot be reached, further communication should be made and other strategies as recommended at sections 7.5 and 7.7 should be considered as appropriate. Meanwhile, the view of the healthcare team on whether CPR is appropriate or not can be documented in the medical record, to assist the team to make the judgment when the patient develops cardiac arrest. However, if consensus fails to be reached despite all reasonable attempts, a DNACPR decision may still be made, but the healthcare team should ascertain that the CPR is clearly futile, have the reasons for the medical decision documented and be prepared to explain the medical decision when complaints arise. The direct involvement of at least 2 registered doctors, one of whom being a specialist, is recommended in the decision-making in this situation.