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Correspondence

Indian Council of Medical Research consensus guidelines on 'Do Not Attempt Resuscitation': Communication is key

Sir,

The policy document on Do Not Attempt Resuscitation (DNAR) by the Indian Council of Medical Research (ICMR) is a welcome milestone in Indian medical history[1]. We are grateful to the ICMR Expert Group on DNAR for this well-considered and helpful guidelines. The lack of guidance on DNAR so far, especially at the end of life, has been a particular challenge for health care delivery in India.

The treating physicians in India have hesitated to activate DNAR orders for patients for whom it would be futile often because of the difficulty of gaining consent from the patient/surrogate. This guidance underlines that the final decision lies with the physician, and there is no obligation for him/her to provide futile treatment like cardiopulmonary resuscitation (CPR) on-demand when it is judged that it would not be successful or desirable. However, when the success of CPR is doubtful, physicians should discuss the same with patient and family and take time to explore patient's wishes and values.

In countries like the UK, the discussion on DNACPR is done with patient/surrogate and the discussion is clearly documented in the patient's medical record. The DNACPR form however, is only signed by the physician[2]. The proposed DNAR form in India includes a place for a signature by the physician and the patient/surrogate. The cultural setting in India is unique, with families being involved in decision making as unofficial surrogates for the patient. This can pose distinctive challenges. While patient autonomy is advocated by medical professionals, large families, the presence of multiple decision-makers and collusion between family members and professional carers are very common and are frequent challenges for the medical fraternity. Since 'collective autonomy' is the norm, it makes sense to have the patient/surrogate sign the form to avoid confusion.

It is important to clearly explain the nature of CPR and its likely success in the light of the disease trajectory and prognosis to all concerned so that the physician is able to fulfill the primary duty to care for the patient while facilitating the family's understanding and minimizing conflict. Good communication in an environment of trust is crucial to make this entire process less burdensome for physicians, patients and families alike. In this context, the signing of the form by the patient or surrogate affirms that a joint decision through adequate discussion has been made. Such discussions and documentation are very relevant in India, where some people have a misconception that not attempting CPR always amounts to medical negligence and may accuse medical professionals of the same. Joint signatures on the form along with documentation of discussions and their outcome in the medical record, will also help prevent medical litigation. Clear and repeated discussions about the prognosis and the aims of ongoing treatment, which at this stage will often be symptomatic or palliative will also protect families from a sense of guilt for having assented to a DNAR order being in place.

The physicians should endeavor to involve the patient in the decision-making process even though the discussions are difficult. However, some patients may choose not to be directly involved in the discussions around DNAR because of the psychological stress involved and may defer to their families. The option on the form to indicate that the patient is not willing to participate in the discussions towards the decision should not, however, be a way for physicians to avoid having these difficult discussions. Surrogate decision-makers should be encouraged to make decisions in the best interest of the patient keeping the patient's values and wishes in consideration. The burden of making DNAR decisions would be lighter if they knew that

this is what their loved one would have wanted, and they are supported by a compassionate physician who has communicated well.

It is noted within the text 'whenever the treating physician is in doubt on whether to perform DNAR or not, CPR should be performed as the default option'. However, this is not rightly depicted in the algorithm[1]. We would presume/suggest that if the physician is not sure of the benefit of CPR, it should be done unless the patient has expressed a wish not to have it. If time permits, more clarity on the likely benefit of CPR should be sought through discussion with other physicians, as mentioned in the document[1].

There is a need for sensitization and training of doctors, beginning in the medical colleges for medical students where communication skills should be taught, including training on holding such difficult conversations. We now have a helpful guidance document, but good communication is the best instrument to enhance joint decision making. Teaching materials and videos can serve as powerful aids to upskill medical professionals[3].

We once again are grateful for the policy document, which will facilitate careful joint decision making and promote dignity in death for many.

***Conflicts of Interest*:** None.

Jenifer Jeba[1,*], **Ashita Singh**[2] **& Dan Munday**[3]
[1]Palliative Care Unit, Department of Radiotherapy, Christian Medical College Hospital, Vellore 632 004, Tamil Nadu, [2]Department of Internal Medicine & Palliative Care, Chinchpada Christian Hospital, Nandurbar, Maharashtra, India & [3]Centre for Population Health Sciences, Usher Institute, University of Edinburgh, Edinburgh, UK
[*]*For correspondence*: jenifermugesh@yahoo.com

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