

DNACPR AND END-OF-LIFE CARE DECISION, COMMUNICATION, AND MANAGEMENT

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A. Ethical Question

How should clinicians decide on DNACPR in the context of end-of-life care, and how should these conversations take place?

B. Scenarios

1. A 75-year-old man in the SARI ward presented with cough and cervical lymph nodes enlargement with lung nodules on CXR, possible malignancy or TB. He's lonely & depressed, eventually refused any blood monitoring & lymph nodes biopsy.
2. An 80-year-old man with triple vessel heart disease, NYHA Class III, and two previous ICU admissions, currently suspected to have COVID-19 and needs ventilatory support. Patient's goals and wishes unknown, eldest son from overseas wants "all-out."

C. Background on CPR and DNACPR during COVID-19 Pandemic

1. **Survival rates for cardiac arrest:** Pre-COVID, hospital survival for in-house cardiac arrest (IHCA) with non-shockable rhythms is often < 15% (1). The mortality for critically ill COVID-19 patients increases with advancing age and co-morbidities, particularly cardiovascular disease (2). Thapa et al. (1) reported that for in-house cardiac arrest (IHCA) involving 54 patients, 52 (96%) had a non-shockable initial rhythm, 29 (54%) achieved return of spontaneous circulation, and none survived to hospital discharge (95% CI, 0%-6.6%). Many had non-shockable initial rhythms, presumably as a result of progressive respiratory pathology, and potential delays in resuscitation from donning of PPE. Nevertheless, these results must be interpreted with caution, given the small sample (3), and the effectiveness of CPR in the era of COVID-19 must be taken into consideration. Hayek et al. (4) in a multicentre cohort study across 68 ICU in the U.S. reported out of the 5019 patients, 701 (14%) had an IHCA, and 48 (12%) survived to discharge, and only 28 (7%) discharged with normal or mild neurological impairment. Pulseless electrical activity (49.8%) was the most common rhythm, followed by asystole (23.8%). **They concluded that cardiac arrest is common in critically ill patients with COVID-19 and is associated with poor survival, particularly among older patients.**
2. **CPR safety, timing, and effectiveness:** Adequate training and PPE during CPR are crucial for safety. Further information could be obtained from the MOH Guidelines on Resuscitation during COVID-19 Pandemic – Version 3/2020 (2). Any delays could be mitigated by the anticipation of a cardiorespiratory arrest, preparation of PPE and space in advance, and adequate training for different scenarios to ensure effectiveness. DNACPR orders assist the resuscitation team in situations where outcomes may be less favourable. Delays should be minimised in confirming code status.
3. **DNACPR:** A do-not-attempt-cardiopulmonary-resuscitation (DNACPR) order provides a mechanism to withhold cardiopulmonary resuscitation (CPR) in the event of a cardiac

arrest. This may be respecting the wish of the patient/family who refuses CPR, or the medical team determining that the risks outweigh the benefits, or the likelihood of CPR success being low owing to the underlying medical condition. CPR measures do not include other life-sustaining therapy (LST), or analgesia, antibiotics, drugs for symptom control, feeding or, hydration, investigation and treatment of a reversible condition, suction, etc.

D. Decision-Making for DNR Order and End-of-Life care during COVID-19 Pandemic

Definition

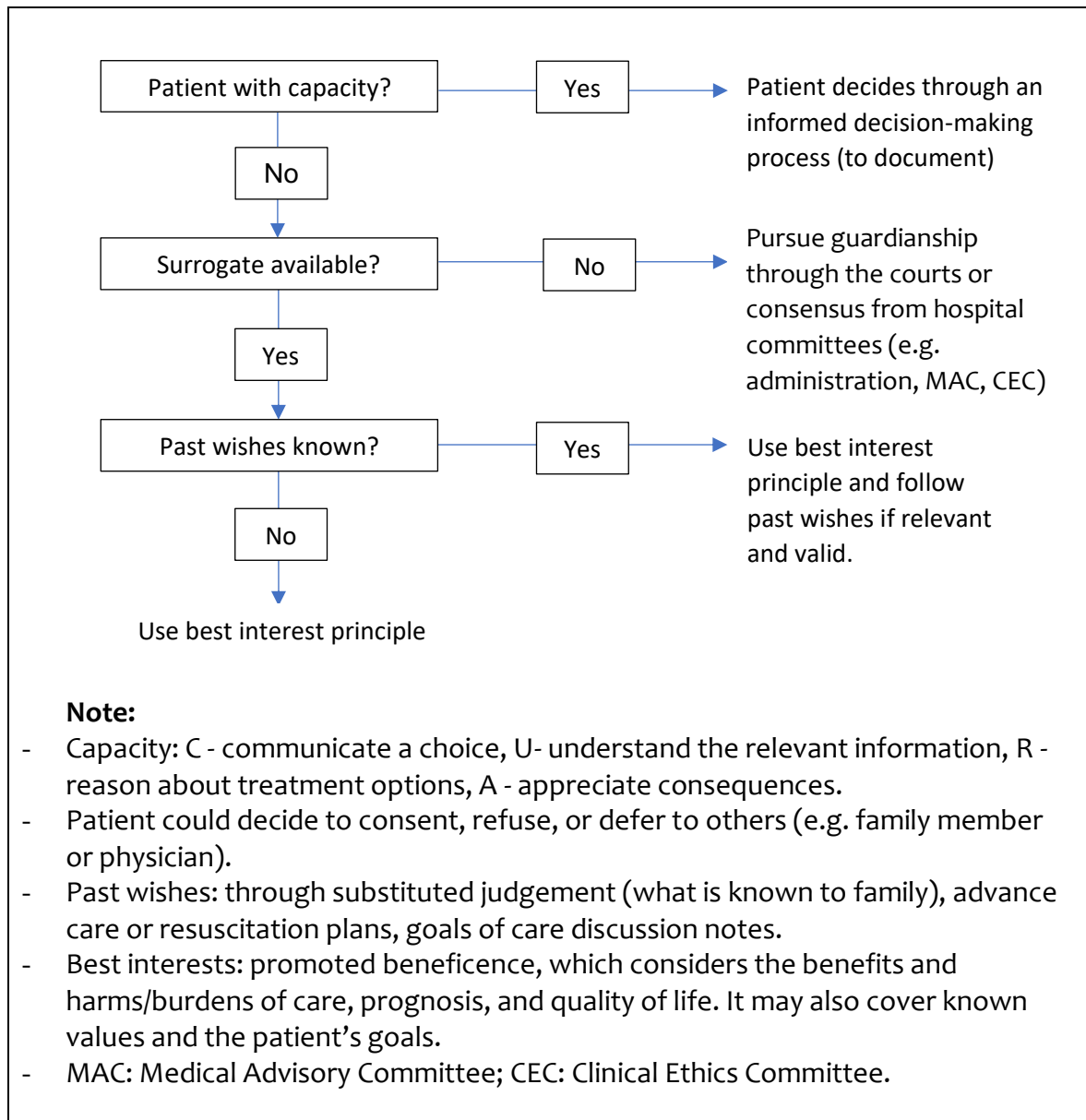
1. **DNR and end-of-life discussions:** It is rarely appropriate to decide and discuss DNR in isolation from other aspects of end-of-life care (5). Often, healthcare providers view DNR orders as a blanket decision for conservative management (e.g. not for intubation, chest compression, and other life-saving therapies such as dialysis). In fact, after a disclosure (breaking bad news including death-in-line, DIL), discussions should revolve around and the goals of care. Goals of care (GoC) discussion includes the overall disease trajectory, benefits/risks/burdens of current life-sustaining therapies, patient's goals and values, and the care that matters to the patient now, with his best interest in mind.

Exploring patient's values and preferences

2. **Where to locate patient's preferences?** Some patients with terminal illnesses or life-limiting diseases may have wishes or goals. These conversations may be accessible in the form of advance care planning, patient-held medical record/note, electronic medical record, or a contact with the primary or palliative care team.
3. **Who decides?** If the patient has the capacity, he/she could decide or defer to others if preferred (e.g. a family member or the physician) (2,3,4). If he/she is incapacitated, the available surrogate decision-maker could use substituted judgement and consider decisions based on what the patient would have wanted. Through a shared decision-making process, the physician and surrogate decision-maker rely on best interest principle in consideration of patient's values and preferences (Figure 1).

Figure 1: Proposed Framework for "Who Decides?"

CHAPTER 2: DNR AND END-OF-LIFE CARE
Best Practice in Clinical Ethics and Compassionate Care during COVID-19 Crisis



Psychosocial and cultural dimensions

4. **Personalised approach** – There are extensive background psychosocial and cultural dimensions to consider in the context of death and dying. Clinicians need to be culturally competent about various cultures and faiths (6,7) and embrace cultural humility (8) in recognition of knowledge gaps and biases. They could undertake a personalised approach to explore the psychosocial and cultural dimensions of individual patients that may, or may not, be related to their original socio-cultural backgrounds and upbringing, stated faith, educational level, past experiences, perceived identities, and their relationships with others. It is prudent for clinicians to ask and not assume while taking a psychosocial history, understand the “how” and “why” of decision-making through the patients’ perspectives, and be conscious of their own cultures, including the culture of medicine.

What to decide?

5. **Best interest principles (BIP)** should be used for critical decision-making. BIP is used when a patient does not have the capacity to decide for him or herself, especially for life-sustaining treatment, e.g., no CPR or dialysis or vasopressors. BIP is a promoted beneficence framework, which includes the considerations of disease trajectory, survival, prognosis, quality of life, and benefits/harms/burdens of care. It may also cover known values and the patient's goals. The clinical and ethical principles in decision-making should apply to both COVID-19 and non- COVID-19 patients.
6. **Initial resuscitation** - During the COVID-19 pandemic, although “it is reasonable to consider age, frailty, comorbidities, and severity of illness in determining the goals of care and establishment of DNACPR directives” (2), it is clinical and ethically justified that patients with co-morbidities receive treatment and intensive care at the start, especially when the underlying diagnosis and prognosis have not been established. In fact, timely intervention is needed, given pre-existing co-morbidities (9).
7. **What's next?** Healthcare providers should focus on care that matters to the patient, avoid intensive life-sustaining therapy when they are non-beneficial, burdensome, or unwanted. Avoiding non-beneficial or unwanted high-intensity care also becomes especially important in times of stress on healthcare capacity (10).
8. **Exceptions to be treated** during COVID-19 could be considered in the presence of previously stated wishes from terminally ill or dying patients. An informed refusal for unwanted or non-beneficial interventions should be respected. Nevertheless, if the patient has the capacity, it is important to confirm their wishes. At times, they are temporarily incapacitated secondary to the disease, e.g. hypoxic or uremic. Thus, it is prudent to consult with families if needed.
9. **End-of-life care:** It is ethically acceptable to proceed with non-escalation of therapy, withdrawal or withholding of non-beneficial or medically high-burdens life-sustaining therapy (LST) in the presence of futility through team consensus and shared decision-making framework, when time permits. Ethically required measures for end-of-life care include palliative care steps and intensive symptoms management.
10. **Time pressure situation** – When time permits, always aim for team consensus and an informed approach. Under time pressure, such as during the critical phases of the COVID-19 pandemic, decisions should be made desirably by at least two specialists (one from the primary team), and communicated empathetically to family members by the senior members of the team.

When and what to discuss?

11. **Disclose first, then discuss** - To ask about DNR/DNACPR before breaking bad news or assessing values and goals leads to ineffective code status (10) and end-of-life discussions. At the onset of serious acute illness during COVID-19 pandemic, disclosure (breaking bad news/DIL) should be held early (e.g. at the ED) to align expectations, followed by goals of care discussions if indicated. Once the patient/family is ready, specific decisions could be informed, and necessary management steps carried out.

Figure 2: Quick Note on Breaking Bad News

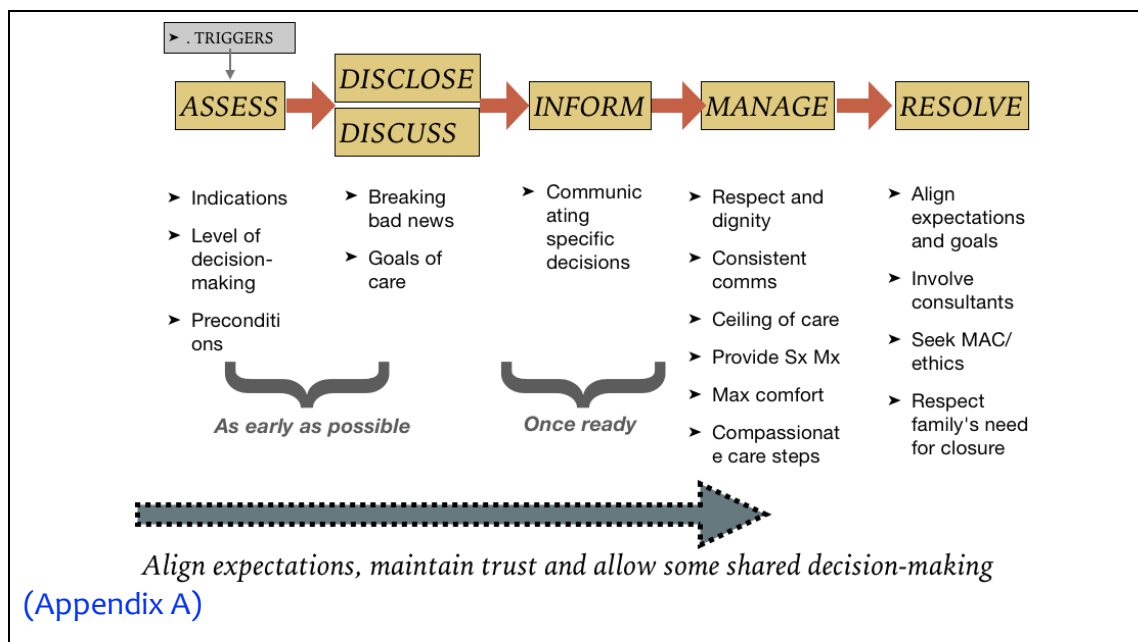
Breaking Bad News	
When?	Imminent death Clinical deterioration Presence of futility
Who?	Specialists or senior medical officers
Where?	Private room at ED, general wards, ICU, PICU
How?	Use SPIKES (Appendix B)

12. **Goals of Care (GoC)** discussions (11) involve the critical conversations between the primary teams with the patient and/or family on the overall disease trajectory, benefits/risks/burdens of current life-sustaining therapies, patient's goals and values, and the care that matters to the patient now, with his best interest in mind.

Figure 3: Quick Note on Goals of Care Discussion

Goals of Care Discussion	
When?	Presence of futility Disease worsening/progression Repeated hospitalisations or ICU admissions Routine discussion for patients with life-limiting conditions
Who?	Specialists and medical officers with patient/family
Where?	Clinic or private space in ED, general wards, ICU, PICU
What?	Overall disease trajectory, continuation of supportive care (limiting non-beneficial, risky, or high-burden CPR/LST), provision of comfort care (including palliative care and intensive symptoms management), and honouring patient goals and wishes.
How?	Use RE-MA-P (Appendix C)

Figure 4: Proposed DNR And End-Of-Life Care Steps
Assessment, Communication, And Management (Summary)



E. Communication for DNR and End-of-Life Care during COVID-19

- General principles** - During the COVID-19 pandemic, opportunities to build rapport and hold proper family conferences are hampered by infection control measures, physical barriers, and time limitations. End-of-life discussions should always be held as early as possible, conducted by the senior members of the team, preferably face-to-face or in-person, considering the patient's wishes and values, and aligning patients/families' expectations and emotions.
- Communication tools** such as SPIKES (Appendix B) and RE-Ma-P (Appendix C) can be used for difficult conversations. Palliative care (Palliative Care Section) and other compassionate care steps (visitation and saying good-byes) (Compassionate Care Section) must be considered at this point.
- Informed assent** – Assent means to agree or to give permission. Advantages of informed assent include:
 - Clinicians could ask family members to allow them to decide and alleviate any psychological burden (10).
 - Family can focus on other end-of-life aspects, including bidding farewell.
 - Clinicians have greater obligations to provide careful prognostication and respectful, open, and thoughtful communication with family members.
- When it is clear that resuscitation (CPR) or life-sustaining treatment (LST) will not be beneficial, it is ethically acceptable that a decision is made and an informed assent is

provided to the family (10). Offering the family an option to decide or withhold an intervention with no benefit may cause more confusion, emotional burden, and guilt to families (5). Thus, a written authorisation for DNR is not required. Clear documentation on DNR or end-of-life discussions will be adequate and should be easily accessible to all teams.

F. Implementation of DNR and End-of-Life Care Steps (Appendix A)

1. Trigger for DNR and end-of-life care discussion:

- a. Poor response to current treatment
- b. Disease worsening/progression with severe major organ(s) dysfunctions/failure
- c. Repeated hospitalisations or ICU admissions
- d. Wishes to limit care explicitly expressed by the patient or family members.

2. Assess the indications of DNR and withholding non-beneficial LST (5,12):

- a. Physiological futility – Patient is facing imminent death (cardiorespiratory failure despite maximum support).
- b. Medical futility - Patient's condition indicates CPR/LST would fail or not sustainable, e.g. in the setting of irreversible organ failure
- c. Quality of life – Patient is terminally ill, and the burdens or risks of CPR/LST outweigh the benefits to the patient, and CPR/LST is unable to achieve his goals or values.
- d. The burden or risks of CPR/LST are more than what the patient/family is willing to accept.

3. Ensure the right level and approach of decision-making:

- a. Team(s)-based consensus should be considered if time permit with a shared decision-making approach.
- b. Under time pressure, decisions could be desirably made by at least two specialists (one from the primary team) and communicated empathetically to family members (12).

4. Ensure preconditions are met before end-of-life or goals of care discussion :

- a. Adequate assessment by senior members of the team (as above in 3.)
- b. Preferably, disclosure (breaking bad news/DIL) has been conducted earlier.
- c. There is some family acceptance, and expectations are somewhat aligned.

5. Disclosure (breaking bad news) and Discussion (on the goals of care):

- a. Disclose and break bad news on imminent death, clinical deterioration, or grave diagnosis (Using SPIKES - Appendix B).
- b. Discuss goals of care with patient/family – Overall disease trajectory, continuation of supportive care (limiting non-beneficial, risky, or high-burden CPR/LST), provision of comfort care (including palliative care and intensive symptoms management), and honouring patient goals and wishes. (Using RE-MA-P - Appendix C)
- c. Inform family of specific decision, e.g. CPR, in an empathetic manner (Figure 5).
- d. Communicate specific decisions within the framework and communication as figure below. (Figure 5)
- e. Communicate face-to-face (video or in-person) with the specialist or senior member of the team.

6. Implement necessary management plans:

- a. Maintain respect for persons and patient's dignity at all times.
- b. Maintain consistent and empathetic communication with family.
- c. Provide best supportive care (13), and limit non-beneficial, risky, or high burden CPR/LST. Consider referring to MSIC 2021 Consensus Statement: A Clinical Guide to Decision-making for Critically Ill COVID-19 Patients ICU Admission and Withholding/Withdrawing Life-sustaining Treatments (16): http://www.msic.org.my/download/MSIC_Statement_Clinical_Guide_to_Decision_Making.pdf
- d. Provide care that maximise comfort, which includes palliative (Chapter 3 - Palliative Care) and symptoms management e.g. adequate control of pain and dyspnoea.
- e. Consider compassionate care steps (Chapter 4 - Compassionate Care) – psychosocial and spiritual support, allow visitation, and saying goodbyes.

7. Maintain quality of care and good clinical governance:

- a. Document all decisions and discussions.
- b. Inform team(s) of plans, ensure continuity and communication of plans.
- c. Debrief teams whenever possible.
- d. Mortality audits or reviews at the department/hospital/state/national level.
- e. Regular review of the processes and workflows according to the latest evidence and feedback from the team(s), with ethics input in policy-making.

8. Consider resolution options in the event of a disagreement (between teams/team-family):
- To align team(s)-family expectations and common goals.
 - To involve consultants or heads of department to arbitrate/resolve conflicts.
 - To seek administrative, medical advisory committee, or ethics consultation/facilitation
 - To respect the family's need for closure by assuring that maximum effort and comfort have been provided.

Figure 5: Informed Assent Framework and Communication for DNACPR

(adapted from Curtis JR et al., JAMA March 2020)(10)

1. Assess patient's values and goals

(elicit value and preferences for therapies and outcomes)

Could you tell me more about your mother? What do you she would have wanted? What matters to you and your mother the most at this point?

2. Discuss CPR as part of the overall goals-of-care discussion

(describe how, when, and why CPR/LST is performed or)

We want to be sure we are taking the best possible care of your mother, so I would like to talk to you about the CPR and also other parts of care and treatment.

3. Summarise the role of CPR

(explain the lack of ability of CPR to achieve patient's goals)

Given what you have told me about your mother and her goals, performing CPR (and/or these interventions) may not be in her best interest or help her to reach her goals.

4. Present a definitive assent statement

(inform patient or family that CPR will not be offered)

Since CPR will not be beneficial, nor achieve your mother's goals in this situation, we do not provide it. We want to discuss other parts of care that are more important to her at this point.

5. Assess understanding and allow for objection

(discuss family's understanding of decisions made, & any objections they may have)

I want to make sure you understand. Do you have any questions?

G. Hospital Policies and Guidelines

Hospital policies should exist for matters related to decision-making during the COVID-19 pandemic. Healthcare administration and policy-makers at the hospital, state, and ministry level could seek legal and ethics input/advice regarding liabilities, ethical issues, or patient-physician disputes resolution during the management of a pandemic.

1. Some of the legal and professional ethics resources:

- a. Malaysian Medical Council - Ethics and Law Unit - drfaizirosli@mmc.gov.my
- b. Medico Legal Section, Medical Practice Division medicolegalkkm@moh.gov.my with the advice and reference to the Ministry of Health Legal Advisors Office.
- c. Medicolegal Units at each hospital.

2. Some of the bioethics and clinical ethics resources:

- a. Hospital Ethics Support Service (HESS), Hospital Ampang ethicsampang@gmail.com. Ethics Case and Non-Case Consultation Referral Form - <https://tinyurl.com/HAethicsconsult>.
- b. Medical Ethics and Law Department, UiTM meld@uitm.edu.my. Clinical Ethics Consultation Service, UiTM marktan@uitm.edu.my or meld@uitm.edu.my
- c. Clinical Ethics Malaysia (CEM) COVID-19 Online Consultation Service by UM/UiTM/IJN: <http://tinyurl.com/CEMConsultForm>

H. Conclusion

Clinicians must be ready to adapt to the various situations during these unprecedented times; and be willing to engage in discussion and formulate, modify, or adapt to new guidelines or recommendations to optimize care. Bedside decision-making dealing with life and death under pressure can be challenging, and therefore early consensus among senior members of the clinical team is essential. Families must be engaged as early as possible in anticipation of patient deterioration to align their expectations. Clear and transparent policies should exist for matters related to end-of-life decisions, e.g. withdrawing and withholding life-sustaining treatment, request of potentially non-beneficial or inappropriate treatment during COVID-19, and CPR.

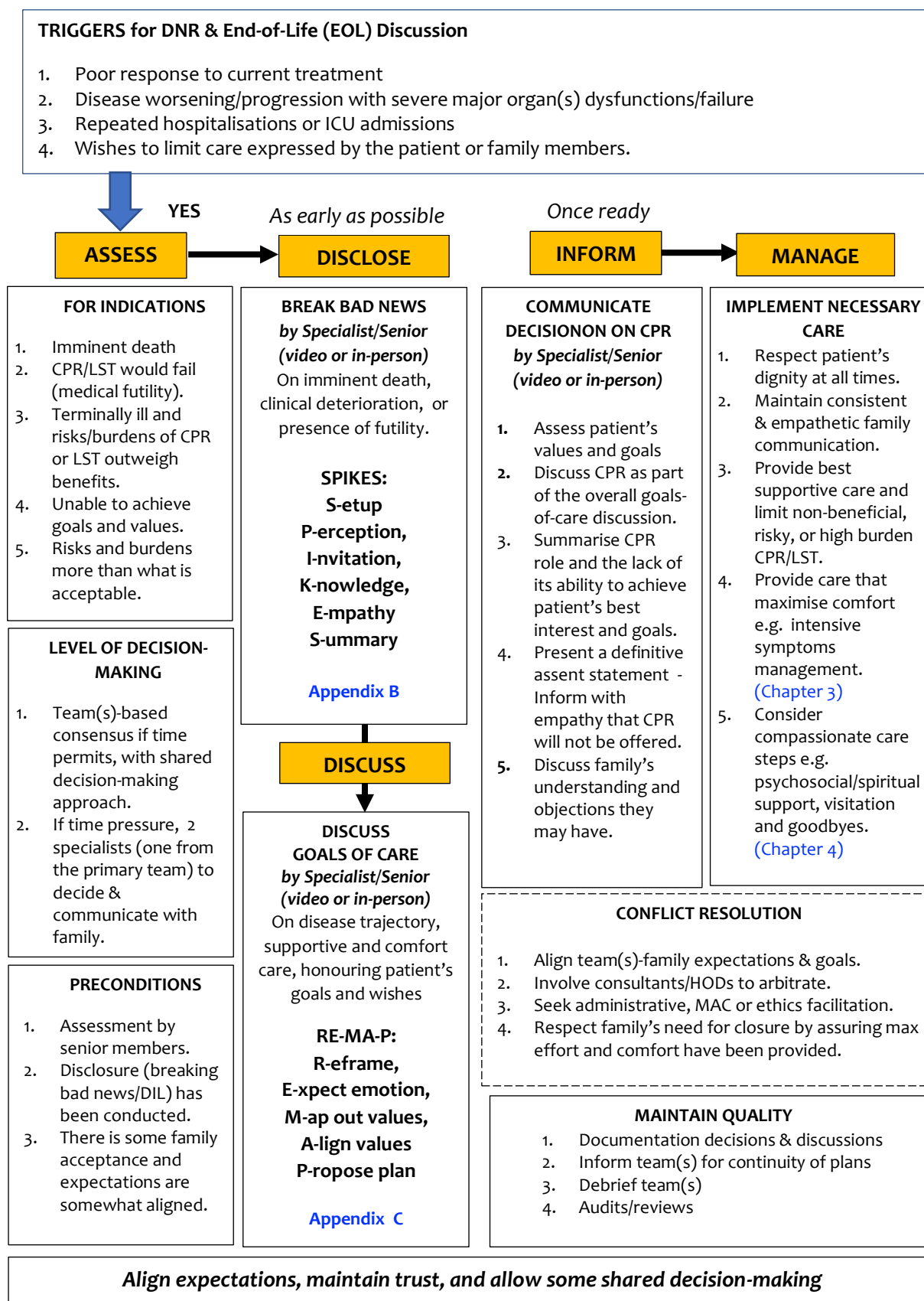
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CHAPTER 2: DNR AND END-OF-LIFE CARE
Best Practice in Clinical Ethics and Compassionate Care during COVID-19 Crisis

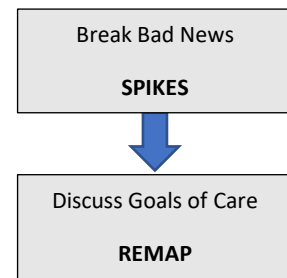
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APPENDIX A: IMPLEMENTATION OF DNR AND END-OF-LIFE CARE STEPS
ASSESSMENT, COMMUNICATION, AND MANAGEMENT



APPENDIX B: Breaking Bad News With SPIKES

When?	Imminent death Clinical deterioration Presence of futility
Who?	Specialists or senior medical officers
Where?	Clinic, private room at ED, general wards, ICU, PICU



S = SETUP. Make sure you are sitting at a quiet place with no interruption. Get ready to engage with the patient/family. Prepare necessary medical facts and be aware of your own emotions and limitations. Introduce yourself and purpose of the conversation.

“Hi, I am Dr. XX, I am the specialist-in-charge of Mr.XX, “Is this...?”, “Is it a good time to talk?”, “I am sorry that we need to talk through the phone about this”, “I understand it has been a difficult time for everyone”.

P = PERCEPTION. Find out what the patient/family knows about the medical situation. Eliciting their concerns can help them feel heard and help you plan.

“What do you understand so far about...”, “Has anyone spoken to you about...?”

I = INVITATION. Find out how much info the patient/family wants.

“Are you the one who makes decisions for Mr. XX”, “Do you have any questions or concerns at this point?”, “How much do you want to know?”

K = KNOWLEDGE. Use language that matches the patient’s/family’s level of education, avoid jargon. Give a warning that bad news is coming.

“I am sorry to say that Mr. XX is not doing well...”, “Mdm XX CT scan doesn’t look good”, “I am afraid to say that she has not been doing well overnight, and I bring you grave news”, “Mr. XX was still doing fine this morning, but he went to the toilet, and he had a fall.”

Break information into chunks. After giving the bad news, provide a suitable pause (several seconds) to allow information to sink in and to observe emotions and reactions - resist the urge to say something.

“I am sorry to say that Mdm XX has passed on”, “I am sorry to say that Mr. XX heart has just stopped, and the doctors are resuscitating him”, “I am sorry to say he won’t make it”, “We are worried that he’s not been responding to the oxygen therapy”, “The family needs to prepare that he might not make it tonight”.

<Silence>

“I wish I could tell you differently”, “I am sorry”.

E = EMPATHIZE & EXPLORE. Wait until the patient/family are ready to talk. Use empathetic statements to name or acknowledge emotions.

“I can see that you are worried,” “Seeing your mom like this must be painful for you”, “I can feel this news has been very sudden to you”.

<Silence>

You can help them hope for the best while preparing for the worst.

“You have done your best to send him in when he was sick”, “We are still trying our best, but we are quite concerned with his current response”, “We hope he’ll respond to the new treatment, but with his lungs, we need to be prepared”.

Take the opportunity to explore goals and values.

“Could you tell me more about her?”, “What do you think she would have wanted?”, “What matters to you and your family now?”

S = SUMMARIZE AND STRATEGIZE. Summarize the medical information and make plans for next step, including further goals of care discussion. Check understanding and emotions, ask if there is anything more they would like to know or you to help.

“This is what we have talked about today”, “It must be a lot to absorb”, “Is there anything you would like to ask me?”

“If he doesn’t respond in the next XX hours, we will need to discuss again what would be the best for him given his current condition”, “We will call you again tomorrow morning.”

“I am sorry for the loss to you and your family”, “It has saddened us that Mdm XX did not make it.”

Steps to Improve Non-Verbal Communication during COVID-19 Pandemic

- Setting: Calm, private, non-interrupted, non-intrusive
- Attitude: Respectful, empathetic, slower tone
- Effective Listening: Nodding, leaning forward, pausing, mirroring
- Gestures: Good eye contact, hand or arm gestures (ok sign, thumbs up etc)

Pitfalls/Common Barriers to Good Communication

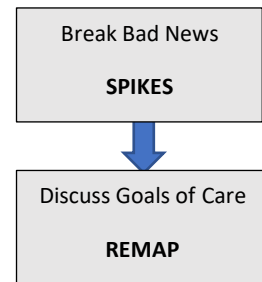
- Assuming that cure is the goal of all patients
- Talking too much and not pausing to listen.
- Feeling you are responsible for maintaining the patient’s/family’s hope
- Making assumptions about what the patient/family knows and doesn’t know

Videos: Delivering bad news COVID-19 short animation - <https://youtu.be/7MRPrP2mdl4>, https://youtu.be/BC3Yklm88_Y (good video), <https://youtu.be/HWAZnhCuAeE> (bad video).

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APPENDIX C: Discussing Goals of Care with RE-MA-P

When?	Presence of futility Disease worsening/progression Repeated hospitalisation or ICU admissions Routine discussion for patient with life-limiting conditions
Who?	Specialists and medical officers with patient/family
Where?	Clinic or private space in ED, general wards, ICU, PICU
What?	Overall disease trajectory, continuation of supportive care (limiting non-beneficial, risky, or high-burden CPR/LST), provision of comfort care (palliative care and intensive symptoms management), honouring patient goals and wishes.



Note: Clinicians converse on Goals of Care (GoC) when current therapies are not working, by discussing prognosis, exploring patient values, attending to emotion – to develop a plan.

R = REFRAME. Assess patient’s/family’s understanding of the illness and trajectory. *“What do you understand so far about...”, “What are your feelings about how her situation now?”*

Provide new information, if necessary. Go for the “bigger picture” of the illness, and by re-evaluating the whole situation – “re-evaluate where we are”, justify the need to revise the GoC. *“Yes, we had the same concerns”, “To recap, Mdm XX came to us with...for the past 1 week had needed maximal intensive care”, “As we know, she had an underlying (medical condition) that caused her to have a complicated infection...so we had put her on...and closely monitored for a response.”*

“I am afraid to say that we don’t see much of improvement. In fact, she is deteriorating....”

“We have been trying our best, but we felt the time has come to discuss with you and your family about what is best for Mdm XX at this point, her treatment plans and what we should do if her heart stops.”

“We are worried that the intervention/whatever we are giving her now is causing more pain and harm to her, and this might not be in her best interest.”

E = EXPECT EMOTION. Emotional cues may be verbally explicit, or nonverbal such as crying. Reflective statements that acknowledge emotion help the patient/family feel heard. **<Silence>** (Questions asked by the patient/family right after the reframe are often expressions of emotion rather than requests for information)

“I could see that you are frustrated”, “I could see that you are upset”, “It must have been so hard for you and your family”, “I hear you”, “I wish it had been different.”

Check if the patient is ready to move to the next step. “Would it be OK to talk about what this means for Mdm XX?”. Give more time if the emotion does not dissipate.

M = MAP OUT PATIENT VALUES. Explore patient’s values before discussing therapeutic choices. Use open-ended questions. Another way is to ask about the patient’s life outside the hospital or previously, to discuss meaningful and unfinished goals.

“Could you tell me more about Mdm X?”, “What do you think she would have wanted?” “To find out the best plan that works for both Mr. X and your family, let’s talk about what is most important to your father and you at this moment?”

A = ALIGN VALUES. Verbally reflect back what the patient/family has expressed, including any doubts. Make a hypothesis about what this means, and summarise these reflections in an understanding of the patient’s values and priorities.

“So, you are saying now that he would not have wanted to be on a ventilator this long”, “So, what I could understand now is that Mr. X has wanted a peaceful end with his children by his side”, “So, what is most important to you and your family now is that she should not suffer more, given how much she has fought with her cancer previously?”

An alignment has occurred when the patient/family responds something like “That is exactly right—that’s what most important.”

P = PROPOSE A PLAN. If the patient/family is ready, propose a medical plan that one believes has the best chance of maximizing the patient’s values and goals, using both information about the patient’s values and the feasibility of medical treatments to help achieve the goals. Take account of what degree of burden and risk the patient/family is willing to accept.

“I believe it will be best that we focus on care that helps her and keeps her comfortable, according to what she would have wanted”, “I propose that we continue to support her and allowing treatment that does not bring her too much of unnecessary pain, we will keep her comfortable with mask oxygen and medications, would that be alright for you and your family?”

“If her heart were to stop, it is often that her organs had ceased to function after being critically ill, and that chest compression will not be able to revive her in a meaningful way.”

“We want to make sure that you could see her soon, or through a virtual visit, the least we could do to help arrange.”

Videos: Discussing goals of care with a patient - <https://youtu.be/mQoYVPDH87s>, <https://vimeo.com/402742230>

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