

DNR policies in North America: A procedural morass - resuscitation practices revisited

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Abstract

More than twenty-five years have elapsed since the first Do Not Resuscitate (DNR) policies were proposed. A historical review of the application of DNR policies is provided with its rationale and perceived effects. A viewpoint is presented, that acceptance of implied consent for cardiopulmonary resuscitation (CPR) in hospitalized patients was responsible for drawing up of DNR policies. Unfortunately, the principle of informed consent as related to CPR and DNR policies, has had unintended consequences. Practical results do not indicate that medical practices have become more humane. Abuses of the process go beyond matters of style and experience, in communicating with surrogate decision-makers. Instead of generating compassion and respect for the patient, policies may contribute to cynicism and lack of caring amongst physicians. Overly optimistic dependence on advance directives to reform medical practices, appears unjustified. The concept of futility to limit demands for non-beneficial care is examined. It is unlikely that physicians can routinely invoke futility, as an argument to limit treatments. A re-examination of DNR policies as a defense against technologic imperative is warranted.

Key words: CPR, DNR, ethics.

If we pause to reflect at the time and energy spent on arriving at Do Not Resuscitate (DNR) decisions in the U.S. hospitals, we may ask the question as to how we got here? For all practical purposes, even if the patient is obviously dying, doctors and nurses presume that everything must be done to keep the patient alive, until DNR designation has been discussed, agreed upon and recorded in the patient's chart! Of course, the process requires discussions with the attending physicians, patient if awake and family members. Many physicians and surrogates, for whatever reasons, do not agree to the DNR designation. It sets up the stage for repeated

attempts by nurses or physicians to convince surrogates to avoid CPR. In hospital parlance, this refers to obtaining an appropriate 'code status'. In contentious cases, the institutional ethics committee may be approached. The debate often constitutes the entire agenda of institutional ethics committees. Ironically, the more healthcare institutions attempt to deal with difficult bioethical issues, more tangled the policies and procedures become. The basic question left unanswered is, have the DNR policies made care of the dying, more humane?

Historically, No CPR and DNR designations have been used interchangeably. DNR has become more accepted as an all-encompassing term to include both an actual physician order, as well as a process that has many other aspects, besides cardiopulmonary resuscitation. The early policy makers took great pains to show that they were not advocating abandoning patients, by avoiding

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CPR. Subtle moral difference between killing and letting die, continues to elude most non-physicians. The medical profession may have been less than successful in explaining the difference. Unfortunately, the debate is still cast in terms of "saving" lives, versus "letting" them die. This is despite the dismal survival statistics of attempted CPR in hospitalized patients. Moreover, in all hospitals, if no decision has been made, the benefit of doubt entails providing the most aggressive form of treatment. Thus, presumed consent for CPR has evolved into entitlement. Actual experience shows that most family members of patients believe that a CPR will be performed in the hospital, regardless of cause of death. This 'default' position is rarely ever challenged in setting the hospital policies.

Why DNR? A perspective

The idea of avoiding cardiopulmonary resuscitation (CPR) in a patient, who was going to die anyway, was a reaction to the hospital policies adopted en masse in the 1960s. These policies stipulated that CPR would be attempted on every patient, about to die in the confines of a hospital. Snider points out that routine in-hospital use of CPR occurred without any mandate from an accrediting agency, or a state department of public health.^[1] Not only a new standard of care appeared overnight, but also a highly intrusive intervention was to be provided without the physician's orders. All this happened barely 6 years after the first report of external cardiac massage appeared in the medical literature.

The revulsion that the new 'routine' caused amongst lay public and professionals, gave birth to DNR orders.^[2] A working group at Massachusetts General Hospital, while admitting the influence of the recently decided Quinlan case, declared that the use of heroic measures to sustain life can be justified only by adherence to dictates of both *sound medical practice and patient's right*, to elect or decline benefits of medical technology. Unfortunately, the informed consent debate, which antedated DNR issues by just a few years, got thoroughly mixed up. Thus, the stage was set to confuse the resuscitation topics, with obtaining consent for elective surgery.

An early attempt at using patient categories according to expected outcome was made at Mount Sinai Hospital in New York by Tagge and colleagues.^[3] They described

a simple classification system by categorizing patients into four classes, ranging from maximal therapeutic effort, to stopping life support systems. Interestingly, the categories were strictly for the use of ICU personnel, with no concurrence required by the surrogates. The family members were to be spared the onerous task of having to make decisions to limit therapy. Grenvik and colleagues at the University of Pittsburgh refer to the guidelines, a committee developed in 1975.^[4] These investigators also devised four categories from total support, to brain death. Discussion with family members and wishes of the competent patient are mentioned, but *without the requirement* that they concur.

Though these policies have been widely copied and modified, few institutions have had as satisfactory an experience, as the early investigators anticipated. Differing interpretations of categories, ambiguity about the role of surrogates and uncertainty about laws, make matters difficult. The orderly progression of disease envisioned in the suggested categories is a rarity. A number of patients with chronic illnesses repeatedly seek intensive care and stake a claim on life-saving technology. In these patients, it is not possible to define treatment goals. The fact that the patient survives a treatment, becomes the rationale to continue treatment! At the time of devising patient care categories, the physicians did not imagine that patients or their relatives would challenge placing patients in specific categories. The basic difficulty for physicians resides in the attempt to obtain consent for a procedure, such as CPR, that is to *avoided and no easy solution exists for it.*

Relevant questions

If the purpose of DNR policies is to assure that unnecessary suffering of patients in the hospitals be avoided, it is appropriate to pose the question whether they have been successful? The legal devices of living will or durable power of attorney may facilitate the process, but the stated goals are not always met. Danis and colleagues have documented that the patient's previously expressed wishes are less likely to be followed, when advance directives were present on the chart.^[5] The well-conceived SUPPORT study, identified unrelieved pain and suffering in over fifty percent of the surviving elderly patients.^[6] The health care providers seem to desire explicit and specific directions to forego treatments. The families are often hopelessly confused

and divided, as the physicians concentrate on the technical aspects of life-support devices. Thus, every patient-family faced with withdrawal of treatment goes through a process of making decisions, when least prepared.

Politics of DNR

It commonly falls to the junior physicians to deal with emotionally distraught relatives, making sensible discussion about the goals of therapy, impossible. A fairly prevalent practice of the attending physicians is to change the resuscitation status of patients, in order to admit them to the ICUs. More recently, it has been observed that patients' relatives do not disclose durable power of attorney or living will, until it is quite late. They often are fearful that the doctors would give up 'too early'! On the other hand, many of them may agree to painful short-term treatments, that are not likely to save a life.

Of course, the precise definition of 'short-term' is quite variable. Thus a valid concept of 'timed-trials' has become counter productive. This state of affairs is possible, because DNR policies were crafted to allow for maximum flexibility, i.e, if patient's condition improves, the DNR order is rescinded. Unfortunately, though rarely examined, common abuses of the process perpetuate cynicism, lack of caring, and half-hearted attempts at satisfying the irate family members, or unreasonable physicians.

Kass identifies the problem of using a *technical ethical* solution for problems produced by our already foolish tendency to seek *technical medical* solutions, for weighty difficulties of human life.^[7] He has suggested that DNR protocols are an attempt to engineer, rather than inculcate values in practice. When normative medical standards are ignored, the medical profession feels helpless as patients, or more often, their surrogates demand useless or marginally effective therapies.

DNR-A Weak Defense Against Technological Imperative

Most studies have shown that DNR decisions are made late and after all, available treatments have been tried.^[6] Once a no CPR decision has been entered on patient's chart, there will continue to be a need to discuss additional procedures. The decisions related to dialysis, feeding tubes, tracheostomy, infected vascular catheters,

or bedsores are common. They may even require trips to the operating room, when DNR orders are temporarily suspended. As such, a DNR patient in a persistent vegetative state is as likely to enter an operating room or ICU, as a previously healthy patient.

Unfortunately, substituting the patient's values as justification for treatments, tends to remove them from objective review. By focusing narrowly on the act of cardiac compression, we divert attention from a number of other issues. In the medical records, one frequently finds phrases such as 'continue supportive therapy'. Do we believe that the patients and surrogates pay no emotional or financial price for 'supportive care'? It may at best be disingenuous to let time decide for us.

Emotions, rather than logic, appear to determine our decisions about the usefulness of resuscitative measures for those we love. The DNR decisions may serve as balm to the troubled conscience of both medical establishment and patient surrogates. However, the experience of the last several years does not indicate that medical practices have become more humane.

The Concept of Futility?

Blackhill in 1987 pointed out that the issue of patient autonomy was irrelevant, when CPR offered no potential benefit to the patient.^[8] "If CPR is offered as hope to family members, it is cruel", she reasoned. Her position received support from Tomlinson and Brody, who elaborated that futile medical care need not be offered, or in fact discussed with the surrogates.^[9] They argued that if patients and families wrongly imagine a benefit from futile treatment, it does not generate a right. Subsequently, they explained their views and were supported by others.^[10-12] Schniderman *et al.* defined a medical treatment as futile, that had been useless in the last 100 cases where it has been attempted.^[13]

Objection to use of futility arguments

Contrary opinions were expressed by Lantos *et al*, who suggested that futility might be an illusive concept in medicine.^[14] In the context of CPR, Truog and colleagues have argued that a few hours of survival may be so valued by the family members. that it is a worthwhile goal.^[15] Veatch and Spicer, in an exhaustive article, have argued that *medically futile* treatment does not exist.^[16] In fact, they doubt the competence of physicians in judging any

treatments as futile. They believe that physicians are referring to socially futile treatments, for which they have no experience! That ethicists see futility debate as a thinly veiled attempt by physicians to revert to paternalistic behavior, is understandable.

Thus it is clear that very divergent views of medical futility as an argument for limiting treatments, exist. From a practical point of view, very few physicians are likely by themselves to invoke the futility argument, or act upon it. Most physicians are not aware of their institutional policies regarding futile treatments.

Whether informed consent is germane to discussions when CPR is unlikely to succeed, is the topic of a scholarly article by Scofield.^[17] Was DNR a 'solution' that has not worked? "Patients can no more marginalize the legitimate concerns physicians have about their integrity, and the need to set reasonable limits, than physicians can dismiss patients through futility exception." Scofield summarizes as crux of the matter.

Treatment decisions incorporating concept of futility

The Houston group has sought to improve on the process of implementing medical futility decisions in the hospital setting.^[18] They recognized that any futility policy based on a substantive definition, was unworkable. Houston policy insists that physicians not act unilaterally, ban intrainstitutional transfers and insists that the patient not be abandoned. The authors claim that their policy for the first time, emphasizes institutional and individual professional integrity. In a recent paper, Casarett and Siegler have provided data on ethics consultations over two years, where unilateral do-not-attempt resuscitation orders were sought by the physicians.^[19] They have used a Houston type of model, and expressed cautious optimism.

We are still left with the question, whether futile treatments are provided to the patients for non-medical reasons? Whether it is done in the name of promise keeping or some other moral principle, the practical implications are the same.^[20,21] If we imply that the only consideration for making decisions for the incompetent is that the surrogate loves them or knows their wishes, then the inherent goodness of the decision does not have to be examined. Can physicians totally ignore issues of efficacy, without jeopardizing the objective basis of

modern medicine? The irrational nature of patients' or surrogates' choices has been well documented by Danis and colleagues.^[22]

Alternatives to Current Policies

Not only we need to recognize the shortcomings of DNR policies, we also need to rethink the context in which these policies have evolved. DNR policies may have been a necessary step in our desire to share decision-making with patients who are likely to die in the hospital. But DNR policies have failed in achieving their stated purpose of humanizing the care of the dying.

It is our experience, that thoughtful considerations are often lacking when administering CPR. Some suggestions, which should be considered, are presented in an article with reference to Indian practices.^[23]

Briefly

1. Adoption of universal CPR in all hospitalized dying patients is *not* necessary.
2. The hospitals should *allow* unilateral DNR decisions by the responsible physicians, but insist on disclosure and written justification.
3. The brain death laws should be rationalized to *include all* patients who meet the clinical criteria. This situation is peculiar to India, where the laws regarding brain-death apply to *only* organ donors.
4. Establishment of *ethics committees* in academic and large hospitals which are entrusted with the review of DNR policies, including futile care.
5. Because of the difficulty to enunciate value-free *futility policies*, safeguards must be built-in to protect patients' legitimate interests.
6. Impart *education* in bioethics to medical students, residents and practicing physicians.
7. The professional medical societies embark on a plan to *educate* judiciary, legislators and public, about the limits of medicine and relief of human suffering.

We also need to be sensitive to the public criticism, that the procedural maze set up by the hospitals is meant to protect institutions and physicians from the threat of lawsuits. Worse still is the often-expressed belief, that DNR policies represent a money-saving measure.

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