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Ethical Issues: DNR Revisited

In most cultures, when making treatment decisions for adults, children, and neonates with end stage illness, there tends to be universal agreement that overly aggressive treatment should be discouraged when death is near and further intervention is felt to be futile.ⁱ This includes the use of CPR, artificial hydration and nutrition, unnecessary diagnostic procedures, and interventions that may sustain life but not necessarily provide optimal patient comfort. There also tends to be growing emphasis on hospice care and the use of advance directives in patients who are close to death.ⁱⁱ However, treatment of patients with chronic illness, but who are not necessarily actively dying, varies widely because many practitioners simply don't know when and where to draw the line until the specter of death is irrefutable.

One study examined medical treatment of incompetent elderly patients with life-threatening illness in seven countries and found considerable variability of aggressive treatment. Up to 40% all physicians surveyed chose a level of care different from what had been requested and 10% would have tried cardiopulmonary resuscitation despite a "Do Not Resuscitate" request.ⁱⁱⁱ Indeed, U.S. physicians tend to follow requests for limiting treatments such as CPR less than half the time, even when clear directives are given to the contrary.^{iv}

Writing a DNR order may seem like an act of abandonment for some physicians. They may fear reprisal from families and colleagues who would accuse them of "giving up too soon" or not being skilled enough to ultimately save the patient's life. Physicians' training and professional heritage of always striving to "defeat" death and disease frame a decision-making context of always trying to do something for and to the patient, even if the chances of success and ultimate recovery are minimal. There is also frequently assumed that when a DNR order is written other forms of potential and ongoing treatment should be abandoned as well, which is not necessarily a correct assumption.

Personal feelings about limiting life saving interventions is a matter of acuity and degree. DNR orders limit the use of a specific form of intervention (CPR) during life threatening situations of acute cardiac or pulmonary arrest, but which is felt to be either unacceptable to the patient or otherwise biomedically futile by the physician. However, an order to not resuscitate, in circumstances where the prognosis is poor for survival and there is high risk of injury, does not automatically pertain to other forms of elective life saving intervention that may be acceptable to the patient. A patient with metastatic lung cancer and community acquired pneumonia may choose to undergo elective endotracheal intubation and ventilation as a bridge to recovery from pneumonia, with the hope of being able to return home for the few months of life remaining. But, that same patient may request a DNR order during that same hospitalization, knowing that the chances of

survival and recovery from CPR are minimal. Patients who would not want CPR routinely may elect to undergo elective procedures and allow DNR orders to be suspended while undergoing procedures such as cardiac revascularization or pacemaker insertion with the understanding that, should cardiac or pulmonary arrest occur then resuscitation efforts, and beyond that any ongoing life support, should not be prolonged beyond a reasonable trial period.

Depending on the patient's values and treatment goals many forms of intervention (artificial hydration and nutrition, ventilation, pressers, defibrillation, pace making devices, etc) may be acceptable for a time, whereas acute resuscitation may not because CPR are typically in poor outcomes and increased suffering. Morbidity and mortality from CPR for patients with chronic illness are very high, whereas other forms of intervention, though still risky, may have better predictability for attaining their intended outcomes.

DNR orders designate the withholding of a very specific and aggressive form of life saving intervention and do not necessarily directly link to other forms of treatment that may offer some hope or help to the patient. Such orders are acceptable while proceeding with other interventions, as long as there is clear understanding and documentation as to the intent of the DNR order and the treatment goals of the patient.

ⁱ McHaffe, H, et al. Withholding/Withdrawing Treatment from Neonates: Legislation and Official Guidelines Across Europe. *J Med Ethics*, 1999; 25:440-446.

ⁱⁱ Voltz, R, Akabayashi, A, Reese, C, et al., Attitudes of Healthcare Professionals Toward Clinical Decisions in Palliative Care: A Cross-Cultural Comparison, *J Clin Ethics*, 1999; 10 (4): 309-315.

ⁱⁱⁱ E. Alemayehu, et al. Variability in Physician's Decisions on Caring for Chronically Ill Elderly Patients: an International Study. *Canadian Med Assoc J*, 1991; 144(9): 1133-1138.

^{iv} The SUPPORT Principle Investigators. A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients. The Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatments (SUPPORT). *JAMA*. 1995; 274(20): 1591-1598.