Ethical Issues: Do Not *Attempt* Resuscitation (DNAR)

Orders not to resuscitate ("DNR") designate the withholding of very specific and aggressive forms of emergent life saving interventions (cardiac and pulmonary resuscitation-CPR), which by definition are specifically intended to revive persons who have just died. Patient preferences not to undergo CPR do not necessarily include other life saving treatment that may also save life but are used electively and in a controlled, nonemergent setting--dialysis, elective endotracheal intubation, antibiotics, pressors, electrical cardioversion, etc. Aggressive treatment short of CPR may be acceptable to some patients with incurable end stage disease who do not want to be saved if death is imminent as long as there is a clear understanding and documentation as to the intent of the treatment and the treatment goals of the patient.

When we offer "resuscitation" to patients they may be mislead into thinking it will be successful—"just like on TV." In the majority of cases, however, CPR is unsuccessful even in the most tightly controlled clinical situations. The way physicians phrase their comments to patients and how CPR is portrayed in the media may greatly misrepresent clinical reality. In one study of 60 occurrences of CPR in 97 television episodes (31 on *ER,* 11 on *Chicago Hope,* and 18 on *Rescue 911)* most cardiac arrests were caused by trauma; only 28 percent were due to cardiac arrest. Sixty-five percent of the cardiac arrests occurred in children, teenagers, or young adults. Seventy-five percent of the patients survived the immediate arrest, and 67 percent appeared to have survived to hospital discharge.[1] In reality CPR has a grim prognosis at any age. A 30 year Meta analysis of almost 20,000 cases of in hospital CPR revealed that patients younger than 70 years of age had a success rate of 16.2 percent versus 12.4 percent for patients older than 70 years. Interestingly, community hospitals had a higher CPR success rate than teaching hospitals (18.5 percent versus 13.6 percent), which may reflect the acuity of cases found in tertiary care settings. 72.9 percent of post-CPR deaths were within 72 hours and 1.6 percent of successfully resuscitated patients had a permanent neurological impairment.[2] In frail elderly and demented patients survival following CPR is dismal (0-4%) regardless of the clinical setting and for patients in long term care facilities CPR survival is essentially 0.[3]

Responsible and shared decision making by physicians with patients about the indications and preferences of CPR requires that patients be appropriately educated about the procedure's risks and benefits. In doing this it is also important to convey clear and realistic probabilities of outcomes and that resuscitation will be "attempted" rather than "provided" when CPR is undertaken. Knowing and documenting patient preferences reflected in both verbal or written health care directives, as well as the newly enacted "Out of Hospital DNR" (OH-DNR) forms that will soon be legally available to citizens of Missouri, will also provide support for the decision to write a DNAR order and maintain it through and following hospitalization.

At UMHC a new "Do Not Attempt Resuscitation" (DNAR) policy is going into effect.[4] This new policy will enact several changes and be more reflective of the clinical needs of our patients:

- The new order form takes into account the possible existence of out of hospital DNR (OH-DNR) orders that may come with patients, in which case the DNAR will go into effect immediately when they enter the hospital.
- The order form requires documentation of any health care directives and the person with whom the discussion occurred regarding DNAR status.
- The 24 hour requirement for redocumenting code status upon transfer to a different service and for attendings to sign has been extended to 48 hours, but there is no automatic discontinuance of any DNAR order upon transfer between services or on admission if a DNAR (or OHDNR) already exists and has not been discontinued by a physician's order at the time of transfer.
- The new nomenclature (DN*A*R) is now being used to more accurately represent what we are offering patients when a code is called, noting that CPR is most often not successful when "attempted".
- The order also now only represents the emergent use of cardiac and/or pulmonary resuscitation attempts ("code blue")--elective limitations of other life sustaining interventions (such as the feeding tubes, dialysis, antibiotics, elective intubation, pressors, etc) should be documented in the orders and EMR separately.
- A *DNAR note* template will be made available in the EMR that can be used to document and provide justification when a DNAR order is written. Note that such documentation is required at the time a DNAR order is written and when ever a change occurs in DNAR status. Documentation can be provided by either using the template or free texting in the EMR.
- It's important to remember that patient's can change their mind about code status at any time. The potential futility of doing CPR is a matter that needs to be addressed carefully and succinctly with patients and their family should they choose CPR recognizing a poor prognosis for survival.

Writing a DNAR order can be very difficult for many physicians. Feelings of "giving up too soon" or not doing enough to ultimately save the patient's life are difficult to deal with professionally and personally even when the situation is clearly futile because our training and mind set are to "defeat" death and disease at any cost. It also may be assumed that when a DNAR order is written other forms of treatment should be abandoned as well, which is rarely a correct assumption. Though death may be inevitable and treatment futile, care is never futile. There is a time and a place for DNAR status and it should be utilized with wisdom and sensitivity, as with any intervention for our patients. When the order is written, however, this is the time for the healer in us to step forward and provide the intensity of care and compassion that our patients and their families need more than ever during their final moments.

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[1] Diem S, et al. Cardiopulmonary Resuscitation on Television — Miracles and Misinformation. *NEJM*. 1996;334 (24):1578-1582

[2] Schneider A. et al. In-hospital Cardiopulmonary Resuscitation: a 30-year review. *J Am Board Fam Pract.* 1993;6(2):91-101

[3] Gordon M. CPR in Long Term Care: Mythical Reality or Necessary Ritual? *Annals of Long-Term Care: Clinical Care and Aging*. 2003;11(4):41-49

[4] UMHC Policy I-A-07 Do Not Attempt Resuscitation