FAST FACT AND CONCEPTS #24
DISCUSSING DNR ORDERS—PART 2

Charles F. von Gunten, MD PhD and David E. Weissman, MD

The basic steps in the DNR discussion for seriously ill hospitalized patients were described In Fast Fact # 23. If you have followed those steps, what do you do if the patient or family/surrogate continues to want CPR and you think it is not in the patient's best interest? The seemingly unreasonable request for CPR typically stems from one of several themes:

1. Inaccurate information about CPR.
The general public has an inflated perception of CPR success. While most people believe that CPR works 60-85% of the time, in fact the actual survival to hospital discharge is more like 10-15% for all patients, and less than 5% for the elderly and those with serious illnesses. This is a time to review/clarify the indications, contraindications, potential outcomes and morbidity of CPR. Start an discussion by asking, "*What do you know about CPR?"*

2. Hopes, fears and guilt.
Be aware that guilt (I haven't lived nearby to care for my dying mother) and fear (I am afraid to make a decision that could lead to my wife's' death) are common motivating emotions for a persistent CPR request. Some patients or families need to be given an explicit recommendation, or permission from the physician, to stop all efforts to prolong life, to be told that that death is coming and that they no longer have to continue "fighting". Whenever possible, try to identify the underlying emotions and offer empathic comments that open the door to further conversation: *This decision seems very hard for you. I want to give you the best medical care possible; I know you still want CPR, can you tell me more about your decision?*

Agreeing to a DNR order for many patients is equivalent to their "choosing" to die. Acceptance of impending death occurs over a vastly different time course for different patients/families; for some, it never occurs. Some patients see CPR as a "last chance" for continued life. Probe with open-ended questions: *What do you expect to happen--What do you think would be done differently, after the resuscitation, that wasn't being done before?* Most patients usually describe hope for a new treatment. Use the opportunity to respond by describing that you are doing everything in your power to prolong their life before a cardiopulmonary arrest---you wouldn't be "saving something" to do after they had died. If patients are not ready for a DNR order, don't let it distract you from other important end-of-life care needs; emphasize the goals that you are trying to achieve; save a repeat discussion for a future time; good care, relationship building and time will help resolve most conflicts.

3. Distrust of the medical care system.
Patients or families may give you a clue that there is a fundamental distrust of doctors or the medical system; this should be addressed openly. *What you said makes me wonder if you may not have full trust in the doctors and nurses to do what is best for you? can you tell me about your concerns?*

Managing Persistent Requests for CPR
Decide if you believe that CPR represents a futile medical treatment—that is, CPR cannot be expected to either restore cardiopulmonary function or to achieve the expressed goals of the patient (3). Physicians are not legally or ethically obligated to participate in a futile medical treatment. (some facilities have a policy that a physician may enter a DNR order in the chart against patient wishes). Your options at this time include:

- transfer care to another physician chosen by the patient/family;
- plan to perform CPR at the time of death---*but don't end the discussion*. Engage the patient about their wishes if they survive the resuscitation attempt. Tell them that you need guidance because it is very likely that if they survive CPR, they will be on life support in the ICU, and they may not be able to make decisions for themselves; ask them (or the family) to help you

determine guidelines for deciding whether to continue life-support measures. If not already done, clarify if there is a legal surrogate decision-maker.

References

Cantor MD et al. Do-Not-Resuscitate orders and medical futility. Arch Int Med 163:2689-2694, 2003.
Layson RT and OcConnell T. Must consent always be obtained for a do-Not-Resuscitate order? Arch Int Med 156:2617-2620, 1996.
Diem SJ. Lantos JD. Tulsky JA. Cardiopulmonary resuscitation on television. Miracles and misinformation. New England Journal of Medicine.1996;334(24):1578-82.
Council report: medical futility in end-of-life care. JAMA 1999; 281:937-941.

Fast Facts are edited by David E. Weissman, MD; Palliative Care Center, Medical College of Wisconsin. For comments/questions write to: dweissma@mail.mcw.edu. The complete set of Fast Facts are available at EPERC: www.eperc.mcw.edu