

# Fast Fact and Concept #023: DNR Orders in the Hospital--Part 1

## 2nd Edition

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DNR discussions with seriously ill patients should always take place in the context of the larger goals of care, using a step-wise approach. Prior to any DNR discussions, physicians must know the data defining outcomes and morbidity of CPR in different patient populations.

### 1. Establish the setting

Ensure comfort and privacy; sit down next to the patient. Ask if family members or others should be present. Introduce the subject with a phrase such as: *I'd like to talk with you about possible health care decisions in the future.*

### 2. What does the patient understand?

An informed decision about DNR status is only possible if the patient has a clear understanding of their illness and prognosis. Ask an open-ended question to elicit patient understanding about their current health situation. It is important to get the patient talking--if the doctor is doing all the talking, it is unlikely that the rest of the conversation will go well. Consider starting with phrases such as: *What do you understand about your current health situation? or What have the doctors told you about your condition?* If the patient does not know/appreciate their current status this is time to review that information.

### 3. What does the patient expect?

Ask the patient to consider the future. Examples of ways to start this discussion are:

What do you expect in the future? or What goals do you have for the time you have left—what is important to you? This step allows you to listen while the patient describes a real or imagined future. Most patients with advanced disease use this opening to voice their thoughts about dying—typically mentioning comfort, family, and home, as their goals of care. If there is a sharp discontinuity between what you expect and what the patient expects, this is the time to clarify.

Listen carefully to the patient's responses; most patients have thought a lot about dying, they only need permission to talk about what they have been thinking. Setting up the conversation in this way permits the physician to respond with clarifying and confirming comments such as:

*So what you're saying is, you want to be as comfortable as possible when the time comes. or What you've said is, you want us to do everything we can to fight, but when the time comes, you want to die peacefully.* Whenever possible, ask patients to explain the values that underlie their decisions: *can you explain why you feel that way?*

#### **4. Discuss a DNR order**

Use language that the patient will understand, give information in small pieces. Don't introduce CPR in mechanistic terms (e.g. "starting the heart" or "putting on a breathing machine"). Never say, "Do you want us to do everything?" "Everything" is euphemistic and easily misinterpreted. Using the word "die" helps to clarify that CPR is a treatment that tries to reverse death. To a layman, when the heart and/or lungs stop, the patient dies.

If the patient and doctor mutually recognize that death is approaching and the goals of care are comfort, then CPR is not an appropriate medical intervention and a clear recommendation against CPR should be made. You can say: *We have agreed that the goals of care are to keep you comfortable and get you home. With this in mind, I do not recommend the use of artificial or heroic means to keep you alive. If you agree with this, I will write an order in the chart that if you die, no attempt to resuscitate you will be made.*

If the clinical situation is more ambiguous in terms of prognosis and goals of care, and you have no clear recommendation, the issue of DNR can be raised by asking: *If you should die in spite of all of our efforts, do you want us to use heroic measures to attempt to bring you back? or How do you want things to be when you die?* If you are asked to explain "heroic measures", then describe the purpose, risks and benefits of CPR in greater detail. The clinical pearl here is to start general and become specific later in the conversation.

#### **5. Respond to emotions**

Strong emotions are common when discussing death. Typically the emotional response is brief. The most profound initial response a physician can make may be silence, providing a reassuring touch, and offering facial tissues. (see Fast Fact #29)

#### **6. Establish a plan**

Clarify the orders and plans that will accomplish the overall goals you have discussed, not just the DNR order. A DNR order does not address any aspect of care other than preventing the use of CPR. It is unwise and poor practice to use DNR status as a proxy for other life-sustaining therapies. Consider using words: *We will continue maximal*

*medical therapy to meet your goals. However, if you die, we won't use CPR to bring you back. Or It sounds like we should move to a plan that maximizes your comfort. Therefore, in addition to a DNR order, I'd like to ask my hospice/palliative care colleagues to give you some information.*

See [Fast Fact #24](#) for DNR Orders Part 2

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**Purpose:** Instructional Aid, Self-Study Guide

## Audience(s)

**Training:** Fellows, 3rd/4th Year Medical Students, PGY1 (Interns), PGY2-6, Physicians in Practice

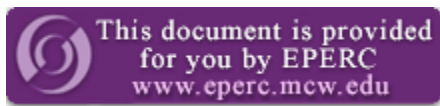
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**Non-Physician:** Clergy/Chaplains, Nurses, Social Workers

**ACGME Competencies:** Medical Knowledge, Patient Care, Professionalism

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## **Fast Fact and Concept #024: DNR Orders in the Hospital Setting -- Part 2**

### **2nd Edition**

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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 a 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.
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