Legal ethical issues and the solutions of a dnr

Sociology, Ethics

Do-not-resuscitate (DNR) orders are those given by a physician indication that in the event of a cardiac or respiratory arrest “ no” resuscitative measures should be used to revive the patient (Pozgar, 2013, p. 153).

Difficulties and confusion about do not resuscitate orders still exist, despite efforts to help patients, families, and surrogate decision-makers make informed choices. In this paper, issues will be addressed about the legal and ethical dilemmas about a DNR, how a DNR can affect while being used in a school system, the history of the issues of DNR, and how potential effects can be addressed to the issues for the future.

Additionally, I will discuss the legal rights of the DNR to individuals as they interact with healthcare services, the implications of the patient’s bill of rights as it reflects to a DNR, and analyze selected ethical and legal case studies that have promulgated precedent-setting decisions. The majority of patients who die in hospital have a “ Do Not Resuscitate” (DNR) order in place at the time of their death, yet we know very little about why some patients request or agree to a DNR order, why others don’t, and how they view discussions of resuscitation status.

Some issues addressed with a study are the patients and families understanding the considerations of a typical request of full code (FC) or DNR orders. DNR patients reported a much greater familiarity with resuscitation discussions than FC patients. This was typically due to previous conversations withhealthcare professionals, experiences with relatives, or self-realization prompted by other experiences. FC patients, on the other

hand, typically reported no previous experience with this discussion, although a few had discussed it previously on admission to hospital.

FC and DNR patients had very different understandings of resuscitation and DNR orders, and there were few common themes identified in their answers. DNR patients described resuscitation as violent or traumatic event, associated with “ tubes” or “ machines,” painful, and generally futile. FC patients, on the other hand, often described resuscitation in a more abstract way, the “ restoration” of life. Finally, a small number admitted frankly that they had no clear idea of what resuscitation actually were (Downar, Luk, Sibbald, Santini, Mikhael, Berman, and Hawryluck, 2011).

Although most patients are pleased with their physician’s approach to the conversation, many reported a negative emotional response overall. Both FC and DENR patients often reported being shocked or upset by the conversation, either because of the timing or the content, or simply being confronted with their own mortality. Advance Care Planning may help reduce this negative response; by normalizing the subject and raising it before an acute illness, physicians may help reduceanxietyand shock when it is raised during deterioration.

Both FC and DNR patients emphasized the importance of honesty, clarity, and sensitivity when discussing this issue (Downar, Luk, Sibbald, Santini, Mikhael, Berman, and Hawryluck, 2011). Mr. H is an 81-year old veteran with a history of chronic obstructive pulmonary disease (COPD) anddepression. His daughters went to visit their father at 10 am and found him awake, but unable to communicate or follow commands. Empty morphine bottles were strewn around the room where he was found. Mr. H’s daughters called an

ambulance and had their father transported to the emergency department of the local VA hospital.

In the emergency department, there was concern for either an accidental or intentional opioid overdose, and the toxicology screen was positive for opioids. Narcan was administered with some modest and brief improvement in mental status, but Mr. H never obtained a level of consciousness that would enable him to express his treatment preferences. Progress notes written during the weeks before the incident indicated that Mr. H had threatened to commitsuicideif his respiratory disease progressed to the point that he could not breathe.

Mr. H was admitted to the medical intensive care unit, where an arterial blood gas showed him to have respiratory acidosis. Several hours after arrival in the MICU, Mr. H became hypotensive and bradycardic. The intensive care resident on duty advised the daughters of her concern that the patient would develop respiratoryfailurethat was likely to lead to a cardiac arrest, requiring CPR. The daughters indicated their father's longstanding wish to be DNR. A durable power of attorney for health care (DPOA) executed five years before, although not documenting any treatment preferences, did appoint the two daughters as health care agents.

The intensive care resident explained to the daughters that it was standard clinical practice to utilize CPR, even if patients had clearly expressed wishes to be DNR, if the arrest of respiratory compromise was secondary to a suicide attempt. The daughters informed the resident that they had had several extended conversations with their father over the last year,

occasioned by his failing health, in which he had communicated to them his wish not to have any aggressive care when his quality of life declined.

The daughters both professed to be devout Christians, but said their father had been an inveterate atheist, whosephilosophyof life was that when an individual could no longer function at an acceptable level, he had the right to refuse all life-sustaining interventions. The resident and the intensive care attending, which had now arrived, did not feel they could ethically or legally enter a DNR order, precluding the use of a life-saving intervention that could potentially reverse Mr. H’s respiratory failure, because it was secondary to a suicide attempt.

At this juncture, the MICU physicians requested an urgent ethics consultation to resolve the conflict. The decision to override the DNR request of an individual who has attempted suicide is often framed as a clear and classical conflict between the principles of autonomy and beneficence or nonmaleficence. The other situation occurs when an individual, having authorized an EMS DNR order, attempts suicide and is discovered before the attempt becomes successful; Both circumstances provoke the classic dilemma, where the ethical wishes of rescuers to act for the good of their patient i. e., beneficence, run counter to the individual’s autonomous wishes expressed in the EMS DNR order.

The rescuer cannot satisfy both of these conflicting ethical principles (Geppert, 2010). A 2010, reviewed of the clinical, ethical, and legal dilemmas related to DNR orders in suicidal patients presents a case report of a patient hospitalized for severe depression, who overdoses on the psychiatric unit and is found unresponsive with a recently obtained DNR order in her hands,

The review argues that contemporary law and policy related to DNR orders are not formulated to encompass the situation of an individual with serious mental illness.

They recommend that patients be screened for suicidal ideation before a DNR order is entered, and that states and institutions clarify their response to DNR status in the context of attempted suicide. “ Passive assistance” occurs when a health care provider does nothing to prevent a patient’s suicide. In the health care context, however, passive assistance has been an ethical practice for many years. For example, DNR orders have been instrumental in forming the current awareness of rights and responsibilities in the area of death and dying.

A physician who refrains from attempting CPR on a patient who has made a rational choice to commit suicide is within the acceptable guidelines of the practice of medicine. If there is disagreement, every reasonable effort should be made to communicate with the patient orfamily. In many cases, this will lead to resolution of the conflict. In difficult cases, an ethics consultation can prove helpful. Nevertheless, CPR should generally be provided to such patients, even if judged futile.

In some cases, the decision about CPR occurs at a time when the patient is unable to participate in decision making, and hence cannot voice a preference. There are two general approaches to this dilemma: Advance Directives and surrogate decision makers (University of Washington School of Medicine, 2008). Do Not Resuscitate Orders in Schools In recent years, legal trends have expanded educational opportunities, including access to

adaptive, for children and adults with wide variety of disabilities or handicaps.

The American Academy of Pediatrics (AAP) has previously addressed the ethical and legal issues involved in decisions to either limit or withdraw life-sustaining medical treatment. Parents, who, after consultation with their pediatrician and other advisors, decide to forego CPR of their child, may want this decision respected by school system personnel. These decisions challenge all persons involved in a situation in which SPR may be given to balance personal beliefs, strong feelings, legal concerns (especially those having to do with liability), educational considerations, and other issues (Pediatrics, 2000).

In contrast, the school officials may be worried that a DNR order could be misinterpreted by medically untrained staff, resulting in harm to a child, or they may worry that personnel would feel bound not to respond to an easily reversible condition, such as a mucous plug in a child with a tracheotomy. Administrators have concerns about their personnel responding to circumstances not anticipated by a DNR order, such as when a child chokes onfoodor is injured. School officials may be rightfully concerned about the effect of a death in school on other students.

The parents of healthy children may not want their children exposed to death in a classroom or other school setting (Pediatrics, 2000). The AAP recommends that pediatricians and parents of children at increased risk of dying in school who desire a DNR order meet with school officials – includingnursingpersonnel, teachers, administrators, and EMS personnel, and, when appropriate, the child. Individuals involved ideally will reach an

agreement about thegoalsof in-school medical interventions and the best means to implement those goals. Concerted efforts to accommodate all points of view will help avoid confrontation and possible litigation.

Pediatricians need to assist parents and schools to review, as needed when warranted by a change in the child’s condition, but at least every six months, plans for in-school care. Pediatricians need to review the plan with the board ofeducationand its legal counsel. Pediatricians and their chapter and district members should work with local and state authorities responsible for EMS policies affecting out-of-hospital DNR orders to develop rational procedures and legal understanding about what can be done that respects the rights and interests of dying children (Pediatrics, 2000).

History of issues with a DNR The development of CPR in the early 1960s precipitated the need for DNR orders. However, it soon became evident that the routine application of resuscitation efforts to any patient who suffered a cardiopulmonary arrest led to new problems. Thus, even in the earliest stages of its development, resuscitative measures presented a basic ethical quandary that still underpins much of the controversy over DNR orders today: the potential conflict between prolongation of life itself and the quality of the life preserved. DNR orders arose out of the need to address such suffering.

In 1974, the American Medical Association noted that “ CPR is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected. ” DNR orders developed out of the general bioethics milieu of the last quarter of the twentieth century, concomitant to “ the promotion of patient autonomy: (Goldberg, 2007, p. 60). While DNR

orders have, by the present day, become a familiar if not regularly encountered phenomenon, “ there is less legal certainty for providers regarding DNR orders for incompetent patients” (Goldberg, 2007, p. 60).

The patient Self-Determination Act of 1990, the 1983 report of the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, and the ruling in Cruzan, Quinlan and other landmark cases established the right of competent patients, through both advance directives and their surrogates, to refuse life-sustaining treatments, providing the ethical and legal basis of DNR orders. Currently, the Joint Commission standards require all health care institutions to have policies and procedures regarding advance directives and DNR orders.

All 50 states have statutory requirements that uphold the autonomy of competent patients to make health care decisions, including those regarding CPR, and to exercise this self-determination through authorized surrogates should they lose decision-making capacity (Geppert, 2010). A Patient’s Bill of Rights Reflected in a DNR DNR comfort care orders permit comfort care only, both before and during a cardiac or respiratory arrest. This kind of order is generally appropriate for a patient with a terminal illness, short life expectancy, or little chance of surviving CPR.

DNR comfort care arrest orders permit the use of all resuscitative therapies before an arrest, but not during or after an arrest. A cardiac arrest is defined as an absence of palpable pulse. A respiratory arrest is defined as no spontaneous respirations or the presence of agonal breathing. Once an arrest is confirmed, all resuscitative efforts should be stopped and comfort

care alone initiated. DNR specified orders allow the physician to “ tailor” the DNR order to the specific circumstances and wishes of the patient.

For example, under this option the physician could specify “ pharmacological code only,” or “ no defibrillation,” or “ do not intubate” (Department of Bioethics, n. d.). If the patients’ preferences regarding resuscitation are clear, they should be respected. Patient preferences to refuse resuscitative efforts can be communicated directly by the patient, or by an advance directive, a valid Do Not Attempt Resuscitation (DNAR) order, or by the patient’s legal representative. Unofficial documentation may be considered when determining patient preferences (ACEP, 2008).

It is appropriate for out-of-hospital providers to honor valid DNAR orders or out-of-hospital advance directives. Standardized guidelines and protocols should be developed to direct out-of-hospital personnel’s resuscitative efforts. When resuscitative efforts are not indicated, emergency physicians should provide appropriate medical and psychosocial care during the dying process. This may include the provision of comfort measures and psychosocial support for the patient and family.

Recommendations to better DNRs

First, to the extent permissible under individual state laws, propose that U. S. hospitals and journals begin to consider the term “ do not resuscitate order” and the abbreviation “ DNR” to be obsolete. These terms carry the implicit message that when interventions such as chest compressions and bag-mask ventilation are undertaken, resuscitation of the patient will result. Suggestion to use the phrase “ do not attempt resuscitation” and the abbreviation “ DNAR,” making clear that CPR is really only an attempt at resuscitation.

Find that DNAR retains clarity about the interventions being discussed while reminding both patients and practitioners of the uncertainty of the outcome of resuscitative efforts. Second, to remind medical learners and practitioners of the questions that must be answered at the time of admission to the hospital. Placing “ attempt resuscitation” status immediately after diagnosis reminds the practitioner that the diagnosis of the patient should play a major role in determining whether resuscitation should be attempted.

This modification in the admission orders also makes the specification of “ attempt resuscitation” and “ do not attempt resuscitation” explicit. While some policies will at first continue to presume consent for CPR, practitioners will be reminded that there is a decision to be made. Third, as a routine part of a discussion the physician should provide an explanation of how the patient’s prognosis would change should the patient experience cardiopulmonary arrest. A cardiopulmonary arrest is not a neutral event.

It is thus not only indicative of the severity of illness, but also an indicator that the prognosis is worse than if the cardiopulmonary arrest had not happened. A discussion of these features can be of particular value to families of patients for whom an event of cardiopulmonary arrest would indicate a worsening of the underlying disease or result in irreversible damage. Fourth, physicians should help clarify prognosis by proposing a course of action to the family. In some instances, that will mean deferring to patient decision, where the medical evidence and judgment is not conclusive.

In other situations, it will mean recommending that CPR not be attempted. Consistent with safeguards ensuring physicianaccountabilityand where

individual state laws would permit broad physician discretion, it might even mean that some cases will necessitate reclassifying CPR as a pseudo-option that does not even warrant a mention. However, a failure to make a recommendation is more likely to cause families additional anxiety than it is to be perceived as coercion.

In addition, making a proposal for a course of action can help a physician communicate the significance of a cardiopulmonary arrest given the patient's underlying condition (Bishop, Brothers, Perry, and Ahmad, 2010, pp. 65-66). In conclusion, when patients' and physicians' understanding of the best decision, or of the preferred role of either party, diverge, conflict may ensue. In order to elicit and negotiate with patient preferences, flexibility is required during clinical interactions about decision making.

A conventional formulation would contend that the origin of the respiratory depression from a suicide attempt was the ethically determinative factor. This perspective would logically have led to the recommendation to override the surrogates' request for a DNR order. Yet this attribution gives more ethical weight to a choice the patient appeared to have made impulsively and proximately, with questionable decisional capacity, rather than the distal and deliberate preference of an individual with intact capacity to refuse life-sustaining treatments (Geppert, 2010).

The four recommendations are only the first steps along a process of a DNR change. The ultimate goal will be to reach a more balanced place where discussions about decisions can be made jointly, but with the acknowledgement that all decisions are laden with moral values inherent in

the practice of medicine and life in a pluralistic society and that all judgments are themselves fallible.