# Do resuscitate status: a legal and ethical challenge for nursing

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Do Resuscitate Status: A Legal and Ethical Challenge forNursingShawn Wolkart Senior Integrative Seminar Spring A semester, 2010 University of Saint Mary Abstract A status of do resuscitate in those critically ill patients may result in a slow code. A slow code is a situation where the nursing staff decides to do less than the standard set forth by advanced life support algorithms and the nurse practice act and allow the patient to die instead of possibly sustaining life. The legal implications include falsification of documents and breaching the standard of care set forth by the nurse practice act.

The ethical issues include malfeasance, dishonesty, and taking on the role of deciding who has a chance to live during a life threatening situation, demonstrating medical paternalism. When I was in nursing school, I did my rotations in a couple of intensive care units (ICU). Often I cared for patients who were very ill and possibly dying. I took very seriously the task of discussing do not resuscitate (DNR) status with the patient andfamily, even as a student. Many times, death was anticipated and those involved were ready to make a decision toward do not resuscitate status.

The legal andethical dilemmaarose when the patient or family was against DNR status and wanted everything done. Some of the intensive care units that I have worked in had an unwritten status of " slow code" that the nursing staff would assign to patients that, according to consensus, would not survive. This slow code meant that the staff would call the code after the patient was too far-gone for successful resuscitation or that advanced cardiac life support (ACLS) protocol drugs would not be given. It may have

been less than adequate CPR or decreasing the concentration of oxygen used.

I had the understanding that life saving resources was not to be wasted on these patients. I heard nurses talk about squirting the drugs into a garbage can or into the mattress of the bed. In one small hospital in a small town, I rotated through a 7-bed intensive care unit. When the manager of the unit would receive a synopsis of the patients and their statuses she would ask about code status. She would tell me that ICU did not need to waste its resources on patients with a do not resuscitate (DNR) status.

I, however, believed that “ no code” did not mean “ no care”. This manager would push the nurses to talk to the family and physicians about making the patient a DNR so they could be moved out to another level of care. For those patients with a dismal prognosis that did not become DNR, the staff would then decide if they should be a “ slow code”. As a new upcoming nurse, this appalled me. How could nurses decide when we gave our all and when we held back? I never participated in these slow codes but I never reported what I heard.

At that time I was certain the manager would have supported or even taught the nursing staff the techniques of slow codes. Performing these slow codes was a breach in legal and ethical conduct. Legally, the charting would include the drugs given that were actually being wasted, constituting falsification of documents. If these nurses were turned over to the legal system, they could have been charged with harm to the patient by with

holding treatment. The nurse’s participation also breached the nurse practice act by not following the standard of care.

Ethically, there are issues of malfeasance, dishonesty, and " playing God" by making decisions about life and death. There were many times that I felt that our efforts were wasted on ninety year old patients with radiation markings for cancer treatment but I always tried to do my best and follow the patients and family’s wishes. I spent time explaining to families the condition of their loved one and what resuscitation did to a body. I wanted the family to understand what resuscitation efforts looked like and the damage they may cause.

My instructor often thought I got too involved. I too did not want to resuscitate a patient dying of pancreatic cancer or from severe head trauma but never felt that I had the authority to make those decisions. Although it has been many years since I rotated through an intensive care, I am sure these issues still arise. As a nurse I worked in the pediatric and neonatal ICU’s and thankfully was not exposed to this type of ethical dilemma. In those instances we did everything we could for those little lives. Today, I would report this to the manager and follow the hain of command. The staff needseducationand training on end of life care and issues, legal and ethical dilemmas in relation to code status, and review of the nurse practice act. Reviewing legal cases and outcomes with the staff may also increase awareness of the dangers of practices such as slow codes. Nurses are to be healing, caring, empathetic and supportive of patients and families during

critical illness, death and dying. At that time, I was just a student nurse and had yet to realize the consequences of this unethical practice.

However, as a manager equipped with the knowledge of the ethical and legal dilemmas of a slow code, my actions today would be different. Involving the ethics committee in these cases would be encouraged. According to Pozgar (2007), “ An ethics committee in thehealthcare setting is a multidisciplinary committee that serves as a hospital resource to patients, families, and staff, offering an objective counsel when facing difficult health care issues and decisions. ” As a manager, I have a duty to care and having staff breach this duty to care would also be myresponsibility.

Falsification of medical records is grounds for criminal indictment, as well as civil liability even if the intent was not malicious. Punitive damages may be awarded even if the falsification did not cause compensable harm (Pozgar 2007). Negligence must also be considered in these slow codes. It could be shown that the patient was not given an opportunity to survive. As a manager aware of these slow codes, I would be prepared to bring disciplinary action against those participating and to report their actions to the state board of nursing as necessary.

This type of behavior violates patient autonomy and is similar to medical paternalism, which involves the health care professional making decisions for those capable of making their own. These actions in slow codes can constitute passiveeuthanasia, involving the withholding of life-saving treatment. (Pozgar 2007) These types of situations and the legal and ethical

dilemmas surrounding them will continue in the future. With machines that can sustain cardiopulmonary function, the medical and lay communities will continue to question what constitutes death and the realities of dying.

We will also continue to encounter situational ethics, where one’s values and moral character can changes with difficult decisions (Pozgar 2007). What I would not change is that staff continues to receive education and support in these difficult situations. After reviewing the material and reflecting on the various legal and ethical issues presented during the course work, my thinking about these events has not changed concerning the legal aspects. Legally, withholding treatment and falsifying documentation is negligence on the nurse’s part, punishable by tort law.

The ethics considerations in these events and others studied presented a plethora of considerations including paternalism, euthanasia, and dishonesty. I would involve administration and the ethics committee to conduct a review of the case and appropriate investigation. If an investigation reveals wrongdoing, the issues encompass the legal, clinical, and public relations perspectives. If the practice is disclosed to the family, civil suits may result. If the practice is disclosed to the community, trust may be affected and the hospital’s reputation damaged.

The administration and medical staff are legally bound and ethically obligated to report information affecting the licensure of professionals involved, including nurses and other physicians. If the facility chooses the course of saving the family the emotional pain of knowing that more could

have been done by not disclosing the slow code, are they really only protecting themselves from further damage? The ethical decisions to be made over known slow codes are not easy, but it remains important that the thought process is a clear as possible.

Any course of action will have practical and moral implications. (Boyle, 2001) The ethics committee is a valuable resource to be utilized when these difficult situations occur. In the past, I viewed the ethics committee as a shadow of administration that was only to be used in the most difficult life and death cases involving comatose mothers and unborn children. However, now the ethics committee can be utilized as a powerful resource for supporting and educating staff, patients, and families. As expansive as the legal issues are in a slow code, the ethical issues are doubled.

The education I have received by participating in this course leaves me confused as to why these practices were allowed and ashamed that I did not do more to properly report this practice. However, I can now take a stance in educating others on the moral, legal, and ethical standards concerning the practice of slow codes. This will remain a challenge, as I recently had the nurse manager of a critical care unit say that slow codes were the best thing that physicians and nurses could do for a patient at times.

Dying with dignity, when patients and families are informed and supported, is a better path than one filled with negligence and dishonesty. References Pozgar, G. D. , (2007). Legal aspects of health care administration (10th ed. ). Sudbury, MA. Jones and Bartlett Publishers, Inc. Boyle, P. J. , Dubois, E.

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