Do-Not-Resuscitate Orders: Nurse’s Role Requires Moral Courage

In the past, the moral command was to choose life. The contemporary moral dilemma is to choose life under what circumstances. “Now, the emerging trend is to cede moral authority – and with it, responsibility – to patients and families (what ought to be done), while scientific authority (what can be done) remains with the professional” (Curtin, 2010, p. 1). This shift is far too simplistic; instead the public and professionals must determine the separation of what ought to be done from what can be done.

Do-not-resuscitate (DNR) orders were initiated as a method to give competent patients the chance to determine under what circumstances they still choose life. Unfortunately, the discussion usually occurs between the surrogate decision maker and the physician, because the discussion has waited too long and the patient now lacks the mental capacity to decide. The focus of this article is the ethical obligation nurses have to support families and patients in making a DNR decision. Initially, a brief review of the statistics on cardiopulmonary resuscitation (CPR), ethical issues surrounding partial do-not-resuscitate (DNR) orders, and the present timing of DNR discussions will be presented. It will be followed by a discussion of the results of Sulmasy, He, McAuley, and Ury’s (2008) study on the difference between nurses’ and physicians’ beliefs and attitudes on DNR. Though this study points to the acceptance of the majority of attendings for nurses to initiate DNR discussions, in reality nurses often are not included in the preparation or implementation of these discussions. Interwoven throughout this article will be ideas about what nurses can do to facilitate more open DNR discussions.

Moral courage will be needed to overcome fear and stand up for the core values surrounding compassionate end-of-life decision making. Nurses need to put ethical principles, such as veracity, fidelity, and autonomy, into action for end of life (American Association of Colleges of Nurses, 2004). Moral courage enables nurses to face up steadfastly and self-confidently to ethical dilemmas surrounding the late timing of DNR discussions and the poor communication by physicians of the bad news about prognosis.

The Truth About CPR All Patients and Families Need to Know

CPR stands alone as the only intervention the patient must state explicitly that he or she does not want. Today, every patient is a “full code” unless a DNR order is documented clearly in the medical record. However, the probability of success of CPR varies based on the cause of the arrest, the patient’s health status, and the availability of a trained first responder (Cooper, Cooper, & Cooper, 2006). Although the right to patient autonomy was expressed in 1914 and informed consent became a catch phrase in 1957, not until 1985 did policies to limit medical care become explicit, in part due to the data on the outcomes of CPR. Discharge from the hospital (definition of long-term survival) after CPR originally was reported as 70%, but this conclusion was based on a select group of patients resuscitated in the operating room and recovery room (Layon & Dirk, 1994). Most current rates of survival are recorded to hospital discharge at 1%-25% for outpatients and 0-29% for inpatients (Cooper et al., 2006). The summary of results from the four large studies of arrest survival demonstrates increased probability of survival for all rhythms when the arrest happens in the hospital (6.4% vs. 17.6%). Patients with ventricular fibrillation fare markedly better than patients in asystole. Current statistics fail to match modern television dramas, however, where 75% of the patients survive in programs such as “ER” (Diem, Lantos, & Tulsky, 1996).

The disparity between these statistics and those of the 1950s is attributed to today’s higher level of patient acuity as well as non-cardiac causes of arrest. Also, this cohort of 50 years ago was primarily surgical patients who benefited from intense monitoring. This cohort also did not demonstrate the brain damage that is a frequent cause of death after cardiac arrest (Safar & Kochanek, 2002). Perhaps these poor outcomes are also the result of CPR being performed...
5. Care plan easily translated by any physician first responder to medical emergency. Discussion of these five elements and the subsequent documentation would provide all physicians and nurses with a clear view of a patient’s desired end-of-life care.

Nurses can support patients in clearly identifying goals of care and desired cognitive and functional ability, as well as weighing the benefits and burdens of recommended interventions. The Code of Ethics for Nurses (ANA, 2001) specifically identified nurses’ obligations in supporting a patient’s interests and right to self-determination, as well as those of the surrogates. The nurse preserves, protects, and supports those interests by assessing the patient’s comprehension of both the information presented and the implications of decisions...The nurse supports patient self-determination by participating in discussions with surrogates, providing guidance and referral to other resources as necessary, and identifying and addressing problems in the decision-making (pp. 8-9).

The physician is responsible to assess competence for decision making and to enter the DNR order in the medical record (Lemienbre, de Casterle, Van Craen, Schotsmans, & Gastmans, 2007). However, nurses have the ethical obligation to assure the patient or surrogate has timely and frequent discussions on the changing goals of care in order to make appropriate decisions.

The Patient and Family Who Need Help

Which patient is most likely to need help gaining access to DNR discussions? Based on the study by Bacchetta, Eachempati, Fins, Hyde, and Barrie (2006), the patient with a diagnosis of malignant disease (with or without metastasis), cardiovascular disease, or endocrinopathy, and the patient receiving chronic glucocorticoid therapy had a higher incidence of DNR orders. The patient who experienced chronic illnesses was more expected to have a DNR order, possibly because that person understood the burdens of life-threatening diseases. A history of dementia, cirrhosis, or renal failure did not influence DNR status in this study.

Unfortunately, the patient who faces life-threatening illness has difficulty gaining access to discussions with a physician for a variety of reasons, one being the physician’s failure to predict accurately and consistently survival or death. A study by White, Engelberg, Wennrich, Lo, and Curtis, (2007) was designed to discover the content of physicians’ prognostic reports to family members of ICU patients. Results indicated families with low literacy rates received less information about potential treatment outcomes and thus may have been more likely to misunderstand the patient’s true clinical picture. Nurses need to advocate strongly for the patient and family in this situation.

Another reason for physician’s disinclination to write DNR orders earlier in a patient’s hospital stay is the emotional and time-intensive nature of this type of conversation. In a study by Morrell, Brown, Qi, Drabiak, and Helft (2008), as well as in the SUPPORT

Partial DNR Orders

DNR orders appeared in the literature in the early 1980s; references to partial DNR appeared before the end of the decade (Ross & Pugh, 1988). Limited data showed bleak survival rates (Dumot et al., 2001). Though “slow codes” have been labeled medically and ethically inappropriate, limited attention has been paid to the ethical issues in partial DNR. “With only particular exceptions, partial attempts to reverse a cardiac or pulmonary arrest are medically unsound because these interventions are often highly traumatic and consistently inefficacious” (Berger, 2003, p. 2271). Such resuscitation commonly violates the ethical obligation of nonmalefice.

What are the medically based exceptions? If cardiac and respiratory arrests are pathophysiologically discrete and the prognosis is good, cardiac resuscitation alone and “do-not-intubate” orders would be acceptable. For example, quick cardioversion for malignant arrhythmias is standard medical practice. Respiratory resuscitation alone would be appropriate for a patient with an asthmatic exacerbation or aspiration of a foreign body, or for an intubated patient with a DNR order who was found self-extubated in respiratory arrest. Mostly “cardiac DNR only” orders are inappropriate for cardiopulmonary arrest because oxygenating a patient without circulation is physiologically senseless and violates nonmalefice (Berger, 2003; Dumot et al., 2001).

Berger (2003) advocated the avoidance of partial DNR orders and instead suggested care plans contain the following five elements for life-threatening conditions in the patient with DNR orders:

1. Identification of the patient’s treatment goals (e.g., maintenance of specific cognitive or functional ability).
2. Identification of specific medical interventions declined because of burden or discomfort (e.g., feeding tubes or hemodialysis).
3. Physician discretion in determining the utility of specific treatments within context of patient’s care objectives (e.g., orders for IV pressors for hypotension due to urosepsis because patient can return to functional level he or she desires).
4. Correlated goals of care with only medically appropriate interventions (e.g., discussion of how pulmonary resuscitation only would not meet patient’s goals).

5. Care plan easily translated by any physician first responder to medical emergency.

The American Nurses Association (ANA) “Position Statement on Nursing Care and Do-Not-Resuscitate (DNR) Decisions” (2003) addresses the duty nurses have in educating patients and families on the realities of CPR and DNR, as well as helping them gain access to explicit DNR discussions with physicians. This position statement also identifies nurses’ obligation to take an active role in developing DNR policies, specifically in clarifying “potentially confusing orders such as ‘chemical code only,’ or ‘resuscitate, but do not intubate’” (p. 2).

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study (Hakim et al., 1996) and other studies conducted in the mid-to-late 1980s, the median time from DNR order to death was 2 days. In the SUPPORT study, only 52% of patients who preferred not to be resuscitated actually had written DNR orders. Despite many initiatives over the past decade to improve the care of the dying (e.g., hospice, palliative care consultation, and competency-based curriculum on delivering bad news for medical students and residents), patterns of DNR ordering have changed little since the passage of the Patient Self-Determination Act in 1991 (Morrell et al., 2008). However, more extensive documentation of discussion of end-of-life wishes was correlated with more and earlier ordering of DNR (30% increase in the time between order and death). This is especially important given the lack of significance advance directives had in the outcome. If physicians resist making the time for these discussions, nurses must muster the moral courage to push for family meetings and, if unsuccessful, for ethics committee consultations.

**Are Nurses Better at DNR Conversations?**

Sulmasy and co-authors (2008) studied the difference between nurses’ and physicians’ beliefs and attitudes about DNR orders. Largely undocumented is the fact nurses already play a role in the process leading to a DNR physician order. Because of their intimate knowledge of the patient and patient advocacy duty, nurses were at least informally involved in DNR discussions. This study surveyed the attitudes of internal medicine attending physicians, medical house officers, student nurses, and medical staff nurses on the topic of DNR discussions, the role nurses ought to play, and providers’ confidence in talking about DNR with the patient and family.

Findings indicated a favorable attitude toward nurses’ initiating DNR discussions (Sulmasy et al., 2008). Nurses were the least likely to find talking about DNR decisions with patients or surrogates as difficult. In fact, unlike the house officers and attending physicians, they viewed these conversations as a gratifying task. They also were more confident in their discussions than house officers, but less confident than attending physicians (p<0.001). Though only 10% of the nurses had a master’s or doctoral degree, no associations existed between confidence and professional training. Neither was there an association with nation of birth, religious denomination, or number of DNR patients treated in the previous month.

Sulmasy and colleagues (2008) noted nurses were not even consulted in the process in many places, yet alone allowed to initiate the DNR discussion. However, 69% of attending physicians in the study agreed nurses should be allowed to initiate DNR discussions. Also, nurses were more likely than physicians to believe it was not their place to recommend a DNR order. Perhaps this nondirective attitude, while not challenging the professional boundaries, supports patients in a different way from the usual physician-directed DNR process. These results raise questions about what policy would best serve the patient’s interests.

**Changing DNR to Allowing Natural Death (AND)**

Family members often misconstrue DNR as giving permission to terminate an individual’s life. However, allowing natural death (AND) makes the intent of the order very clear because death is used in the title. By changing the wording, the acronym is more descriptive and less threatening (Knox & Vereb, 2005).

Venneman, Narror-Harris, Perish, and Hamilton (2008) conducted the first empirical study on the difference between the phrases DNR and AND. Data were collected from 687 participants, with working nurses representing 2/3 of the sample. The remaining 235 participants were almost evenly divided between nursing students and controls (non-nursing students). Even though the working nurses commonly supported the order, regardless of the title (85%), a significantly increased level of acceptance was noted by control group and nursing students. The results of this study support endorsement of a term such as AND.

**Conclusion**

Nurses are on the front line of clinical situations in which lack of DNR orders creates ethical dilemmas requiring moral courage to advocate for the patient and family. According to Sulmasy and colleagues (2008), nurses are ready to take a more active role in initiating these discussions. With nursing intervention, perhaps the partial DNR orders and the late timing of the discussions can be eliminated and the truth about CPR will be told.

**References**


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