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Case and Analysis

Do Not Resuscitate, with No Surrogate and No Advance Directive: An Ethics Case Study

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ABSTRACT

Do-not-resuscitate (DNR) orders are typically signed by physicians in conjunction with patients or their surrogate decision makers in order to instruct healthcare providers not to perform cardiopulmonary resuscitation (CPR). Both the medical literature and CPR guidelines fail to address when it is appropriate for physicians to sign DNR orders without any knowledge of a patient's wishes. We explore the ethical issues surrounding instituting a two-physician DNR for a dying patient with multiple comorbidities and no medical record on file, no advance directives, and no surrogate decision maker. Through this case we also highlight the issues of poor prognostication and the reversal of a DNR in such circumstances.

INTRODUCTION

Although the ethical issues surrounding DNR orders have been amply explored,[1] instances arise when physicians must make this decision for a patient in the absence of knowledge of the patient's wishes. Patients generally arrive at the hospital with a surrogate; some even have advance directives. This case explores the clinical decision making of medical professionals when they must surmise what is the best interest of a middle-aged, dying patient with unclear status regarding comorbid illnesses. We assess the ethics behind DNR in this scenario as well as when such an order should be reversed.

CASE

Mr. G. was a 57-year-old Latino male who presented to the emergency room (ER) in New York with one day of nausea, vomiting, and abdominal pain. The patient presented to the ER alone and had no chart on record within the hospital's electronic medical records system, and no advanced directives or durable power of attorney or Physician Orders for Life-Sustaining Treatment (POLST) forms. His medical history included acquired immunodeficiency syndrome (AIDS), colon cancer with multiple bowel resection surgeries, hepatitis C, and asthma in addition to smoking one pack per day. Upon admission, he was noted to be short of breath and hypotensive—on work up, he was found to be in cardiogenic shock secondary to a large pericardial effusion. Due to respiratory distress, the patient was intubated and subsequently went into cardiac arrest. Mr. G. received CPR for approximately 15 minutes before return of spontaneous circulation (ROSC). As his clinical con-

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dition continued to decline, the decision was made to perform a bedside pericardiocentesis in order to remove the fluid surrounding his heart. Mr. G. had a second cardiac arrest just prior to the procedure. Again he received CPR and was resuscitated. Due to further deterioration in his clinical condition, the patient required high-dose vasopressors to maintain an adequate mean arterial pressure. Therapeutic hypothermia was begun for neuroprotection. In addition, he emergently required continuous venovenous hemofiltration (CVVH) due to acute kidney injury. At this point, Mr. G. was unresponsive with profound cerebral dysfunction.

No family or friends had appeared at the bedside during the approximately 12 hours of his hospitalization, and no member of Mr. G.'s support system could be reached by phone. The patient's wishes for end-of-life care could therefore not be ascertained. As a result of the patient's precipitous decline in overall clinical status and multi-organ failure in the setting of extremely low likelihood of full recovery, a decision was made for a two-physician DNR order to be instituted.

POOR PROGNOSTICATION—ACCURACY AND ETHICS

This case highlights the difficult burden placed on physicians to assess a patient's clinical status and determine the likely outcome of the patient's hospital course. The medical literature is replete with evidence that prognostication by physicians is often inaccurate.[2] The ability to accurately determine prognosis is enhanced by increased contact between physicians and their patients.[3] In Mr. G.'s scenario, the physicians were forced to create a clinical picture of the patient without the benefit of extensive interaction with the patient. Guidelines regarding CPR state that medical professionals are not obliged to provide such care when there is scientific and social consensus that the treatment will likely be ineffective.[4] Although data exist that physicians underestimate the survival or quality of life of chronically ill patients, physicians are tasked with balancing this notion against the idea of medical futility.[5] Since there was no way to preserve Mr. G.'s autonomy, the physicians were forced to emphasize the principle of nonmaleficence.

TWO-PHYSICIAN DNR

DNRs are traditionally signed by a licensed physician in conjunction with a patient or a surrogate decision maker to indicate that CPR will not be performed in the case of cardiopulmonary arrest. This practice came about in the 1970s, after documentation in the medical literature indicated that performing CPR on certain patients actually led to prolonged suffering.[6] At that time, the American Medical Association declared, "CPR is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected."[7] DNR orders raise complex issues related to patients' autonomy and nonmaleficence.

In our case it was impossible to determine the patient's wishes. Additionally, there was no surrogate decision maker or advance care planning available. The 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care provides ethical guidelines for several scenarios surrounding the topic of autonomy as it relates to resuscitation.[8] Even these guidelines, however, make no mention of how a physician should act in such a unique situation.[9]

Due to this patient's poor prognosis and potentially terminal comorbid medical conditions, we raised the question of whether CPR would be medically appropriate. The applicable literature expresses several different viewpoints. Some maintain that physicians do not require consent to withhold procedures or treatments that are not medically indicated.[10] In accordance with the New York State Family Health Care Decision Act (NY FHCDA), when a patient has no medical decision-making capacity, healthcare proxy, or advance directive, no surrogate is available, and two physicians determine that the patient would die imminently even with treatment, the two physicians are authorized to withhold or withdraw life-sustaining treatments.[11] For Mr. G., the physicians determined that it was possible but unlikely that he could have a meaningful recovery with the measures already in place, and he therefore met the NY FHCDA standards. Nevertheless, if he should suffer a third cardiac arrest, death would be almost certain. Due to the recurrent episodes of cardiac arrest, severe multi-organ failure, and potentially significant neurologic damage, a DNR was deemed to be appropriate and was instituted.

Despite the ethical obligation to do no harm, the team struggled with the ethicality of the decision. Ultimately they determined that due to Mr. G.'s significant comorbidities and potential for metastatic colon cancer as the cause of cardiac tamponade, performing CPR and prolonging his life would be unlikely to provide long-term benefit.

Over the following days of Mr. G.'s stay in the cardiac intensive care unit (CICU), his clinical status remarkably and unexpectedly improved. The

cause of the cardiac tamponade was determined to be most likely bacterial rather than neoplastic or tuberculosis. Additionally, his records from a recent hospitalization at a local hospital were obtained, although no previous medical provider for the patient was contacted. The records indicated that the patient's colon cancer had been treated appropriately and that he was regularly followed by an oncologist at the outside hospital. Based on this new information, the attending physician concluded that a DNR order was no longer appropriate, as the patient did indeed have a chance for meaningful recovery, as well as long-term survival.

DNR REVERSAL

Due to the improvement in the patient's clinical course, it was appropriate for the physician to re-evaluate the situation and revoke the DNR order when the likelihood of survival increased.[12]

At this point in Mr. G.'s hospitalization, it became apparent he could survive a third cardiac arrest, but it was unclear whether he would recover full cardiac, pulmonary, neurologic, and renal function. Without a surrogate decision maker who could make decisions on the patient's behalf, it was not clear how the physicians should determine what the patient's wishes would be. According to the 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, "in the hospital the decision to terminate resuscitative efforts rests with the treating physician and is based on consideration of many factors. . . ."[13] In this case, numerous variable factors had to be considered, including the patient's extensive comorbidities, time to CPR, time to ROSC, pre-arrest state, and initial arrest rhythm. No medical algorithm could provide an answer. Ultimately, when there is no information about the patient's wishes, physicians should care for patients in a way that is consistent with what most people choose most of the time, that is, they should try to preserve life.

OUTCOME AND FOLLOW UP

Following discontinuation of the DNR order, Mr. G.'s overall clinical picture continued to improve, however, he still had significant encephalopathy. He remained intubated after two failed extubation trials. During the second re-intubation, a friend of Mr. G.'s appeared at the bedside. The distraught friend reported that he had a 20-year relationship with the patient and informed the team that Mr. G. was a criminal in his former country, and, after fleeing in 1980, had lost contact with his family. Additionally, the friend told the team about the patient's extensive drug abuse history. He also explained that the patient was in fact compliant with all prescribed medications. For reasons unclear to the medical team, the friend did not agree to act as the patient's surrogate and subsequently did not respond to attempts to contact him by phone.

The next decision that the team had to make was whether it would be appropriate to place a tracheostomy, a percutaneous endoscopic gastrostomy (PEG) tube, and a tunneled dialysis catheter in order to continue further aggressive management. There was no consensus among the team members. One physician thought that the patient's prolonged sedation was causing his respiratory depression and that a final extubation trial should be attempted. Remarkably, the patient indeed was able to breathe without an endotracheal tube. As the patient continued to recover over the coming week and his sensorium cleared, his friend unexpectedly returned to the bedside. With the friend's help, the team was able to provide Mr. G. with details regarding the cause of his illness and the course of his hospitalization. One team member reported that she saw Mr. G. cry as his friend narrated his near-death experience, but Mr. G. made no further comments regarding his remarkable recovery. Over the following days, the patient slowly regained the ability to eat, speak, and ambulate. He was transferred from the CICU to a medical floor with the prognosis of a full recovery. Ultimately, the patient was discharged from the hospital on hemodialysis, with significant restoration of cardiac, pulmonary, and neurologic function.

CONCLUSION

DNR orders are recognized as ethically acceptable in instances dictated by both the patient's wishes and medical relevance. Ordinarily, such life-changing orders require the consent of a patient or his or her surrogate. In this case, the medical team was forced to decide the best interests of a patient who was near death without the advantage of communication with the patient or his loved ones. We believe that in such a complicated case, a two-physician DNR was initially appropriate due to severity of illness and high likelihood of death. As the patient recovered, the team members utilized their ethical and medical knowledge to reassess his DNR status. Through this dynamic case, we highlight the medical decision making required of acute intensive care when no advance care planning or surrogate decision maker is present.

DE-IDENTIFICATION OF THE CASE

Informed consent of the patient for permission to publish his case could not be obtained, as he continued to be difficult to reach. Some details have been omitted or altered to protect his privacy.

CONFLICTS OF INTEREST

The authors have no financial or other conflicts of interest to disclose.

NOTES

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