

Position Statements

Nursing Care and Do Not Resuscitate (DNR) and Allow Natural Death (AND) Decisions

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Purpose: Difficulties and confusion about do not resuscitate (DNR) orders still exist, despite efforts to help patients, families, and surrogate decision-makers make informed choices. This statement presents the current literature on barriers that interfere with nurses assisting patients in understanding goals of care and making the decision to have DNR orders written. This statement also makes recommendations for change in the clinical and organizational policy arenas.

Statement of ANA Position: Nurses must advocate for and play an active role in initiating discussions about DNR with patients, families, and members of the health care team. Provision 1.3 of the ANA Code of Ethics for Nurses (2001) states that:

Nursing care is directed toward meeting the comprehensive needs of patients and their families across the continuum of care. This is particularly vital in the care of patients and families at the end of life to prevent and relieve the cascade of symptoms and suffering that are commonly associated with dying. Nurses are leaders and vigilant advocates for the delivery of dignified and humane care. Nurses actively participate in assessing and assuring the responsible and appropriate use of interventions in order to minimize unwarranted or unwanted treatment and patient suffering (p.7).

History/Previous Position Statements: ANA adopted a position statement on Nursing Care and DNR Orders in 2003. This statement was preceded in 1991 by the position statement titled “Promotion of Comfort and Relief of Pain in Dying Patients,” which indirectly addressed DNR concerns.

Supportive Material: Cardiopulmonary resuscitation (CPR) is unique among medical interventions, since it is the only intervention where a presumption to provide the intervention exists, unless there are written physician orders not to do CPR (Bishop, Brothers, Perry, & Ahmad, 2010). Although CPR has been used effectively since the 1960s, the widespread use and possible overuse of this technique and the presumption that it should be used on all patients has been the subject of ongoing debate (Cooper, Cooper, & Cooper, 2006). The efficacy of CPR attempts, balancing of benefits and burdens, and therapeutic goals should be considered in determining if DNR is appropriate. The DNR decision should reflect what the informed patient wants or would have wanted. This demands that communication about end-of-life wishes occur among all involved parties (patient, health care providers, and family; the latter as defined by the patient) and that appropriate DNR orders be written before a life-threatening crisis occurs. If the patient’s wishes are unknown, the patient’s best interest is the prime consideration. The choices and values of the competent patient should always be given highest priority, even when these wishes conflict with those of the health care team and family. An exception to this is when one or more physicians determine that CPR attempts would be medically ineffective or if the decision of the patient/surrogate is in conflict with the informed opinion of the agency/provider as to what constitutes beneficent care of the patient. In this situation, requests from a patient or surrogate will not be honored (Ditillo, 2002). Agency policies concerning the mechanisms for safe transfer of care by providers/agency must be in place. Additionally, if a DNR decision poses special ethical conflicts for a patient’s nurse, mechanisms

need to be in place for transfer of care to another nurse who is competent to care for that patient (ANA, 2001).

Expectations that the Patient Self-Determination Act (PSDA) would facilitate communication about DNR orders among physicians and patients have revealed disappointing results. The PSDA has been shown to have much less influence on DNR orders than other physician variables, such as physician specialty (Morrell, Brown, Qi, Drabiak, & Helft, 2008). In addition, terms such as *resuscitation*, *CPR*, *DNR*, *full code*, and *no code* do not always mean the same thing to everyone (Ells, 2010).

Discussion of DNR status should be included whenever goals of treatment, such as the following, are discussed:

- 1) Benefits versus the burdens of treatment
- 2) Comfort and symptom palliation
- 3) Aggressive attempts to sustain life with the understanding that life-sustaining technology will be withdrawn if it does not meet the goals agreed upon by the health care practitioner and patient or family

(Kolarik, Arnold, Fischer, & Hanusa, 2002; Prendergast, 2001).

Studies show wide variation in whom and what co-morbidities trigger a DNR status. For instance, it has been found that younger patients and cardiovascular patients have a decreased rate of DNR orders written compared to other patients (Holley, Kravet, & Cordts, 2009).

Between 1992 and 2005, there was no improvement in survival among hospitalized elders (65 years old or over) on whom CPR was performed (Ehlenbach, et al., 2009). In this same study, in-hospital deaths preceded by CPR increased and the proportion of survivors discharged home after undergoing CPR decreased. Survival rates were lower for men, individuals with more

advanced age, blacks, and those from nursing homes. Most current rates of survival are recorded at hospital discharge, and range from 1% to 25% for outpatients and 0% to 29% for inpatients (Cooper, Cooper, & Cooper, 2006).

Based on the study by Bacchetta, Eachempati, Finns, Hydo, and Barie (2006), patients with a diagnosis of malignant disease (with or without metastasis), cardiovascular disease, or endocrinopathy, and patients receiving chronic glucocorticoid therapy, had higher incidences of DNR orders. Patients who experienced chronic illnesses were more likely to have a DNR order, possibly because they understood the burdens of life-threatening diseases. A history of dementia, cirrhosis, or renal failure did not influence DNR status in this study.

Unfortunately, patients who face life-threatening illnesses may have difficulty gaining access to a discussion with their physicians for a variety of reasons, one being the physicians' inability to predict accurately and consistently survival or death. A study by White, Engelberg, Wenrich, Lo, and Randall (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 any situation that renders the patient vulnerable because of physical, emotional, or social circumstances.

Good end-of-life care should focus more on what we as nurses provide than what we forgo. According to Dobbins (2007), for patients in long-term care there was no relationship between the presence of formal advance directives and the use of life-sustaining treatments. Also, no relationship was found between the presence of formal or informal advance directives and the

initiation of a comfort care plan. One study found that heart failure patients receive sub-optimal care when a DNR order is in place (Chen, Sosnov, Lessard, & Goldberg, 2008).

Patients undergoing surgery pose special considerations. Regarding suspension of DNR status during surgery, strong arguments have been made that seriously or terminally ill patients who consent to surgery do so because they desire functional or palliative effects (Jones & McCullough, 2008). In that case, automatic suspension or automatic continuation of a DNR order cannot be justified (Ball, 2009). The Association of Perioperative Registered Nurses supports both a reconsideration of DNR or allow-natural-death (AND) orders before surgical procedures and that all risks and benefits associated with surgery and anesthesia be discussed with patients who have DNR or AND orders in place before undergoing surgery (AORN, 2010). An order to allow natural death is meant to ensure that only comfort measures are provided. By using the AND, physicians and other medical professionals acknowledge that the patient is dying and that everything being done for the patient—including the withdrawal of nutrition and hydration—allows the dying process to occur as comfortably as possible.

The American Academy of Pediatrics made a statement of reaffirmation on May 1, 2009, for their policy of DNR orders reevaluation process:

The reevaluation process of DNR orders called “required reconsideration” can be incorporated into the process of informed consent for surgery and anesthesia... By giving parents or other surrogates and clinicians the option of deciding from among full resuscitation, limitations based on procedures, or limitations based on goals, the child's needs are individualized and better served (Fallat & Deshpande, 2004).

The issue of DNR in the operative suite and post-operative setting can present significant problems, if the policy surrounding DNR is not clear. If the DNR is rescinded for an operation, the time period and circumstances under which it is reordered should be specified (Ewanchuk & Brindley, 2006). The conversation and order must be documented in the patient's medical record and communicated to all staff involved in the patient's care.

Slow codes are not ethical, and partial codes often are not appropriate since in most cases they offer even less potential for survival than full codes. Partial codes, at the direction of an advance directive, prohibit one or more of the following: intubation, chest compression, electrical defibrillation, or ACLS medications (Dosha, et al., 2009). "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 nonmaleficence.

However, if cardiac and respiratory arrests are distinct events and the prognosis is good, then cardiac resuscitation orders alone and "do-not-intubate" orders alone 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. Most orders for "cardiac DNR only" are inappropriate for cardiopulmonary arrest because oxygenating a patient without circulation is physiologically senseless and violates (Berger, 2003; Dumot et al., 2001).

Berger (2003) advocates the avoidance of partial DNR orders and instead suggests care plans contain the following five elements for life-threatening conditions in patients with DNR orders. These elements may also assist with discussions regarding goals of care and DNR orders:

- 1) Identification of the patient's treatment goals
- 2) Identification of specific medical interventions declined because of burden or discomfort
- 3) Physician discretion in determining the utility of specific treatments within the context of the patient's care objectives
- 4) Correlate goals of care only with medically appropriate interventions
- 5) Care Plans that can be easily translated by any physician or first responder to a medical emergency

Discussion of these five elements and the subsequent documentation would provide nurses and other members of the interdisciplinary health care team with a clear view of a patient's desired end-of-life care.

There is evidence that nurses often feel that it is not their place to actually recommend a DNR order, although they feel confident about their ability to discuss DNR orders (Sulmasy, He, McAuley, & Ury, 2008). Nurses do, however, have a duty to:

- 1) Educate patients and their families about the use of biotechnologies at the end of life, termination of treatment decisions and advance directives;
- 2) Encourage patients to think about end-of-life preferences in illness or a health crisis;
- 3) Support patients, their families, and their surrogates to have end-of-life discussions with their physicians;
- 4) Ensure advance directives are implemented;
- 5) Communicate known information that is relevant to end-of-life decisions to appropriate health care personnel;
- 6) Advocate for a patient's end-of-life preferences regardless of surrogate decision maker's or physician's desire to not honor them if indeed the preferences reflect beneficent care.

Nurses need to be aware of and have an active role in developing DNR policies within the institutions where they work. In health care organizations, clear DNR policies should be in place that will enable nurses to effectively participate in this crucial aspect of patient care. The appropriate use of DNR orders, together with adequate palliative end-of-life care, can prevent suffering for many dying patients who experience cardio-pulmonary arrest. As primary continuous health care professionals in health care facilities, nurses must be involved in the planning as well as the implementation of resuscitation decisions. According to Sulmasy, He, McAuley, and Ury (2003), nurses are ready to take a more active role in initiating these discussions.

Language matters, and family members often misconstrue DNR orders as giving permission to terminate an individual's life. Alternative ways of discussing DNR may be helpful and are worth investigating. The term *allow natural death* (AND) makes the intent of the order very clear because the word *death* is used in the acronym. By changing the wording from *do not resuscitate* to *allow natural death*, the acronym is more descriptive and perhaps less threatening (Knox & Vereb, 2005). Venneman, Narnor-Harris, Perish, & Hamilton (2008) conducted the first empirical study on the difference between the phrases DNR and AND. Data was collected from 687 participants, with working nurses representing two-thirds of the sample. The remaining 235 participants were almost evenly divided between nursing students and the controls (non-nursing students). Most working nurses (85%) supported the order regardless of the acronym; a significantly increased level of acceptance was noted in the control group and nursing students. The results of this study support endorsement of a term such as *AND* (Knox & Vereb, 2005).

Recommendations

The American Nurses Association recommends that:

- 1) Clinical nurses actively participate in timely and frequent discussions on changing goals of care and initiate DNR/AND discussions with patients and their families and significant others.
- 2) Clinical nurses ensure that DNR orders are clearly documented, reviewed, and updated periodically to reflect changes in the patient's condition (Joint Commission, 2010).
- 3) Nurse administrators ensure support for the clinical nurse to initiate DNR discussions.
- 4) Nursing home directors and hospital nursing executives develop mechanisms whereby the AND form accompanies all inter-organizational transfers.
- 5) Nurse administrators have an obligation to assure palliative care support for all patients.
- 6) Nurse educators teach that there should be no implied or actual withdrawal of other types of care for patients with DNR orders. DNR does not mean “do not treat.” Attention to language is paramount, and euphemisms such as “doing everything,” “doing nothing,” or “withdrawing care or treatment,” to indicate the absence or presence of a DNR order should be strictly avoided.
- 7) Nurse educators develop and provide specialized education for nurses, physicians, and other members of the interdisciplinary health care team related to DNR, including conversations on moving away from *DNR* and toward *AND* language.
- 8) Nurse researchers explore all facets of the DNR process to build a foundation for evidence-based practice.

- 9) All nurses ensure that whenever possible, the DNR decision is a subject of explicit discussion between the health care team, patient, and family (or designated surrogate), and that actions taken are in accordance with the patient's wishes.
- 10) All nurses facilitate and participate in interdisciplinary mechanisms for the resolution of disputes between patients, families, and clinicians' DNR orders (Cantor, et al., 2003).
- 11) All nurses actively participate in developing DNR policies within the institutions where they work. Specifically, policies should address, consider, or clarify the following:
 - A. Guidance to health care professionals who have evidence that a patient does not want CPR attempted but for whom a DNR order has not been written;
 - B. Required documentation to accompany the DNR order, such as a progress note in the medical record indicating how the decision was made;
 - C. The role of various health care practitioners in communicating with patients and families about DNR orders;
 - D. Effective communication of DNR orders when transferring patients within or between facilities;
 - E. Effective communication of DNR orders among staff that protects against patient stigmatization or confidentiality breaches;
 - F. Guidance to practitioners on specific circumstances that may require reconsideration of the DNR order (e.g., patients undergoing surgery or invasive procedures);
 - G. The needs of special populations (e.g., pediatrics and geriatrics).

ANA also supports increased institutional support for nurses requesting family meetings with physicians and other members of the interdisciplinary health care team to address DNR and goals of care.

Summary: ANA supports the rights of patients for self-determination. This right includes the right to a natural death without resuscitative efforts. ANA's *Code of Ethics with Interpretive Statements* (2001), Provision 1.4, supports the right of patient self-determination. In addition, *Nursing: Scope and Standards of Practice* (2010) supports nursing care that protects patient autonomy, dignity, and rights, as well as nursing care that contributes to the resolution of ethical issues. Nurses have an ethical obligation to support patients in their choices, and, when needed, support surrogate decision-makers when they make decisions on patient's behalf, when the decisions of the patient/surrogate do not violate the principle of nonmaleficence. If such decisions pose special ethical conflicts for a patient's nurse, mechanisms need to be in place for the transfer of care to another nurse who is competent to care for that patient. ANA supports mechanisms that encourage nurses to more fully participate in end-of-life discussions with patients and families, including discussions surrounding DNR orders.

Supersedes: Nursing Care and Do Not Resuscitate (DNR) Decisions (2003)

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