On the Permissibility of a DNR Order for Patient with Dismal Prognosis

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Editor’s Note: The following consultation report is based on a real clinical dilemma that led to a request for an ethics consultation. Some details have been changed to preserve patient privacy. The goal of this column is to address ethical dilemmas faced by patients, families and healthcare professionals, offering careful analysis and recommendations that are consistent with biblical standards. The format and length are intended to simulate an actual consultation report that might appear in a clinical record and are not intended to be an exhaustive discussion of the issues raised.

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Question

Is it ethically permissible to write a DNR order and withdraw the ventilator from this patient with a dismal prognosis?

Story

Ann, an 86 year-old woman with past medical history of osteoporosis, was in good health until
the evening of admission when she fell, hitting her head and losing consciousness. Friends observed the fall and called paramedics. Ann was intubated on site and transported to Teaching Hospital where her treatment, including ventilator support, was continued. The trauma surgery team diagnosed her with rib fractures causing a partial flail chest\textsuperscript{1} and a subdural hematoma\textsuperscript{2} and admitted her to the ICU. The trauma team communicated to the family that Ann would not survive this trauma largely due to her age. The treatment was continued overnight, and the following morning the trauma team met with the grieving family and together they decided to place a DNR order in Ann’s chart and withdraw her from the ventilator with the help of the Palliative Care service. However, when the Palliative team arrived and evaluated her they found Ann awake and able to communicate with apparent insight. The palliative physician asked and was told that Ann had not been involved in decision-making. Thus, he requested ethics consultation.

Inquiry during the ethics consult revealed that the trauma team continued to believe that the patient would not survive despite her improved mental state. In questioning the patient, her family, and her friends it became clear that Ann was a remarkable 86 year-old. She lived independently and could easily perform all activities of daily living. She has continued to drive well and has had an active travel and social life. No definitive answer could be given as to whether her being a vibrant, elder patient would change her prognosis. Ann did not have a written advance directive or living will, nor had she previously communicated her treatment wishes.

**Assessment**

Ann has suffered what appears to be a fatal injury. Her physicians and her family believe withdrawal of ventilator support and a DNR order would be appropriate. However, the patient is awake and able to communicate and has not yet been asked to give consent.

**Discussion**

In the event that a patient is incapacitated, treatment decisions are made by a proxy, first turning to written documentation of the patient’s wishes and/or her officially appointed decision-maker. In the absence of written documentation or an appointed proxy, we turn to a surrogate decision-maker. The initial burden on the surrogate is to make decisions using substituted judgment (how the patient would decide in the given situation) based on her previously stated wishes or an understanding of her values. Only if it is reasonably uncertain how the patient would decide can a surrogate decide using the lower standard of what would be in the patient’s best interest.
On the other hand, when a patient has decisional capacity, consent for treatment is obtained not from a surrogate but from the patient herself. At times it is appropriate to include surrogates in decision-making even if the patient has decisional capacity. This is encouraged when a patient’s circumstance could be viewed as decision-making under duress. Surrogates in these contexts would be advocating for the patient and helping ensure the patient’s wishes are being carried out.

When a dilemma arises regarding whether to carry out a treatment requested by a patient or her surrogate when that treatment is thought to be inappropriate by the physician, we must try to determine the nature of the treatment and whether it is ?futile.? Futility can be divided into physiologic futility (the treatment has no possibility of achieving its goal), probabilistic futility (the treatment is very unlikely to achieve its goal), and qualitative futility (the treatment, even if effective, may not be worthwhile). Generally, a physician is under no obligation to prescribe a treatment that meets the standard of physiologic futility. Probabilistic and qualitative futility cases generally require the consent of the patient or surrogate. In this case no documentation of an advance directive or appointment of a surrogate decision-maker appointment is available. Immediate family is present and willing to participate in decision-making. The family has had consensus and gives no clear reason to be disqualified from acting as surrogates should such be needed.

Mechanical ventilation in this case likely falls into the category of probabilistic futility. Though very unlikely to be effective, and even considered inappropriate by some, it is not physiologically futile and is thus ethically permissible. Therefore, the patient or surrogate needs to give consent for withdrawal of ventilator support. Cardiopulmonary resuscitation may or may not be considered physiologically futile in this case. If her physicians believe that her osteoporosis and flail chest make it physiologically impossible to do effective CPR, this should be explained to the patient or family, and a DNR order may be entered in her chart. If, however, they are uncertain of its effectiveness, the use or non-use of CPR should also be discussed with the patient or her surrogate.

The primary treatment team has appropriately based prognostication on research data showing poor survival in elder trauma. These data are surely helpful in communicating expectations; however, we must beware of ageism. Ensuring that each patient is treated as an individual is also important. Further, communication with the patient should not be withheld due to either her age or her prognosis.

This patient has demonstrated enough decisional capacity to be involved in the decision-making process. She should be asked if she would like to be informed of her illness and participate in decision-making. If she chooses not to participate, then a surrogate decision should be sought. Otherwise, she should be asked her preferences in her care after sensitive and realistic explanation of potential benefits and burdens. Her family should be involved in these discussions.

**Recommendations**

1. This patient’s mechanical ventilator should not be removed until she has been involved in
decision-making. Unless her physicians agree that CPR would be physiologically futile, her DNR order should be suspended pending further discussion.

2. If the patient wants to make her own treatment decisions, she should be informed of her condition and prognosis. Treatment options should be discussed, along with her physicians’ recommendations.

3. If she chooses to defer treatment decisions to others, or if she loses decisional capacity before she is able to participate in these decisions, then the family should be turned to as surrogate decision makers.

Follow-up

Ann was asked if she wanted to participate in decision-making. She said that she did. She was informed about her injuries, prognosis, and options. Seemingly handling the information well, she agreed to the DNR order. She gave consent for withdrawal of the ventilator if she became decisionally incapacitated. Her family and her treatment team agreed to follow this directive.

A DNR order was reactivated. Supportive measures, mechanical ventilation, and appropriate therapies were continued including antibiotics for a new pneumonia. Surgical intervention was not deemed possible for her injuries. On hospital day 3, Ann became slightly more somnolent. On hospital day 4 she became comatose and died just prior to further discussion of withdrawing the mechanical ventilator.

Endnotes

1 A flail chest occurs when multiple ribs are fractured such that the chest wall is no longer fixed in position, and the changes in pressure that occur during respiration cause the chest wall to move inappropriately, seriously hampering oxygenation. Treatment includes ventilator support until the ribs heal or are mechanically fixed in place.

2 A subdural hematoma is a blood clot on the surface of the brain that may or may not compromise brain function depending on its size and the presence or absence of progression.

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