I. **POLICY:**

Establishing resuscitation status including Full Resuscitation and Do Not Resuscitate (DNR)/Allow Natural Death (AND), in appropriate hospital patients – A guideline for physicians.

II. **PURPOSE:**

To provide guidelines for discussions with hospitalized patients regarding goals of care, cardiopulmonary resuscitation (CPR), and Do Not Resuscitate (DNR)/Allow Natural Death (AND) orders.

III. **DEPARTMENTS AFFECTED:**

Clinical Services, Medical Staff, Pastoral Care, Supportive Care, Social Services Department

IV. **DEFINITIONS:**

**Cardiopulmonary Resuscitation (CPR)** - The administration of chest compressions, typically combined with artificial ventilation, cardiac defibrillation, and IV cardiac or vasoactive medications

**Cardiac arrest** - occurs when there is an absence of palpable pulse

**Respiratory arrest** - occurs when there are no spontaneous respirations or there is agonal breathing

**Indication for CPR:**
Cardiopulmonary arrest in an unresponsive patient with a clinically reversible disease process or event (e.g. AMI, PE, ventricular arrhythmia). It only applies to an unresponsive, clinically pulseless patient.

**Contraindications for CPR:**
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1. Significant chest wall pathology (e.g. Myeloma, severe osteopenia, severe sternal or multiple rib fractures)
2. Patients who are imminently dying or have no reasonable chance of surviving CPR and ultimately leaving the hospital (e.g. Metastatic cancer with declining function, chronic renal failure on dialysis, sepsis with multiple organ failure, severe acute stroke)

Adverse Consequences of CPR:
1. Chest wall trauma, aspiration
2. Anoxic brain injury
3. Emotional costs to families and staff re: prolonging dying
4. Financial burden to the family and institution

(Points of information regarding CPR: Unfavorable survival factors associated with CPR include: Age > 75, poor performance status, chronic disabling disease, altered mental status, metastatic or hematologic malignancy, and/or “end-stage” disease. CPR is not intended for use in patients dying an expected death from chronic, fatal medical illness.)

V. GENERAL GUIDELINES:

A. Discussions about resuscitation preferences, including DNR, should occur in the context of a broader discussion about end of life decisions which, in turn, should occur in a discussion of the patient’s goals of care.

1. Goals of care:
   a. Goals of care should be discussed with all patients regardless of diagnosis or prognosis, ideally, early in the course of hospitalization.
   b. Each patient or legal surrogate should have the opportunity to communicate the treatment goal or goals that should guide their treatment. (Point of information: The most common goals are cure, live as long as possible, functional improvement or independence, comfort, finishing a life goal, and providing support for family.)

2. End of life and resuscitation preferences discussions should be initiated in the following patients:
   a. Patients with an advanced, life-threatening illness
3. **End of life discussions should address** diagnosis, prognosis, goals of care, and resuscitation preferences (including DNR/AND). Ideally, these discussions should occur in a quiet, private setting. Family members or other persons of the patient’s/surrogate’s choosing should be invited to participate. The physician should sit at eye level during the discussion.

4. **It is appropriate for the physician to make a recommendation** for or against CPR, based upon her/his professional judgment of its anticipated effectiveness. In all CPR discussions, the physician should take the time to fully explain the prognosis and likely disease trajectory, clarify any misconceptions, and elicit the patient’s values and goals, which should form the basis of all CPR discussions. (*Points of information:* A DNR/AND order does not address any aspect of care other than preventing the use of CPR at the time of cardiac or respiratory arrest (death). When discussing CPR using the word “die” or “death” helps to clarify that CPR is a treatment that tries to reverse death. “Do you want everything done?” is unhelpful and is discouraged as “everything” is euphemistic and easily misinterpreted.)

a. Physicians should discuss CPR as a plausible option and recommend “Full Resuscitation” when the relative benefits exceed the harms of CPR or are uncertain (e.g. Patients with chronic illnesses that have not reached end-stage).

b. Physicians should recommend against CPR when there is a low likelihood of benefit and a high likelihood of harm. (eg. Patients with advanced incurable cancer, advanced dementia, or end-stage liver disease.) (*Points of information:* Patients in this group who survive resuscitation are likely to spend their last hours or days in an intensive care unit or have anoxic brain injury. Assent to a DNR recommendation by a patient/surrogate authorizes the physician to write a DNR/AND order. Physicians should assure the patient/surrogate that writing DNR does not mean do-not-treat or that the patient will be ignored or abandoned. The intent of the DNR order in this circumstance is to protect the patient and ensure...
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the best possible experience in the final phase of life. Despite such a recommendation, some patients/surrogates in this category may request that CPR be attempted for a variety of reasons, including religious or cultural beliefs. It is ethically acceptable to acquiesce to such a request as long as it is grounded in the patient’s values and goals and there is a potential for a modicum of medical benefit.)

c. Physicians should not offer CPR to the patient who will die imminently or has no chance of surviving CPR to the point of leaving the hospital. CPR is not intended to be used in this clinical situation. The decision not to offer CPR should be disclosed to the patient/surrogate. (Point of information: Physicians should assure the patient/surrogate that not offering CPR does not mean abandoning the patient, but rather that the intent is to protect the patient from unnecessary harm and to maximize comfort.)

5. The decision reached in the resuscitation conference, whether “Full Resuscitation” or “DNR/AND” should be entered as an order and the content of the conference should be documented in the physician progress notes.

6. Partial resuscitation orders, such as “chemical code” or “no intubation”, are not effective and should not be ordered. “DNR with stable arrhythmia treatment” may be appropriate for patients on telemetry monitoring (Examples of stable arrhythmias - Atrial fibrillation/flutter, hemodynamically stable ventricular tachycardia or bradycardia.)

7. Resuscitation decisions should be reached consensually by the patient/surrogate and the physician. However, patients/surrogates may not demand that a physician participate in futile care. Physicians are protected by Louisiana law from refusal to provide futile care. In such cases, an ethics consultation should be requested and the EJGH Futile Care Policy should be followed. (Points of information: Unreasonable requests for CPR typically originate from one of several themes: 1) Inaccurate information about CPR - While most non-physicians believe that CPR works 60-85% of the time, in fact the actual survival to hospital discharge after cardiopulmonary arrest is 10-15% for all patients and 2% or less for the elderly and those with serious, chronic illness.)
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2) Fear and/or guilt are common motivating emotions for persistent CPR requests. 3) There may be a fundamental mistrust of doctors or the medical system. This should be acknowledged and addressed openly.

B. Patients with Louisiana Physician Order for Scope of Treatment (LaPOST) document that includes a DNR/AND order:

1. The existence of the LaPOST form should be documented during the initial evaluation
2. Confirm with the patient/surrogate that the LaPOST form is the most current copy
3. By state law, the LaPOST orders must be followed and incorporated into the treatment plan
4. The content of the document should be reviewed and discussed with the patient/surrogate
5. Any changes to the document must be made according to the instructions on the back of the document

C. Verbal or telephone orders to implement DNR/AND status are acceptable under the following circumstances:

1. The patient is admitted through the ED and the attending physician is not in the hospital. The attending physician may authorize a DNR/AND order, in consultation with the ED physician.
2. A physician with prior knowledge of a patient’s DNR/AND status may give a telephone/verbal order for DNR/AND status. Once the patient has been personally examined by the physician, documentation of the DNR/AND status should be written in the progress notes or history.
3. When appropriate, an attending physician may authorize a resident to write a DNR/AND order. The attending physician must speak directly to the resident and within 24 hours must document the status in the progress notes.

D. In the event that a patient arrests and there is not a DNR/AND order, CPR will be performed until a physician arrives at the scene to evaluate the situation. If in the physician’s judgment continued resuscitation is inappropriate, the physician will order the resuscitation stopped.

E. Patients who lack decision-making capacity
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1. When a patient lacks decision-making capacity and a legally authorized surrogate decision maker is available, the physician will rely upon the directions of the surrogate.

2. Louisiana law authorizes the following hierarchy to act on said patient’s behalf:
   a. A judicially appointed tutor or curator
   b. An authorized power of attorney for health care decisions
   c. The patient’s spouse, not judicially separated
   d. Any adult child of the patient
   e. Any parent, whether adult or minor, for his/her child
   f. The patient’s sibling
   g. The patient’s other ascendants or descendants
   h. Any person temporarily standing in loco parentis

3. If the patient’s surrogate decision maker requests that a patient have a DNR/AND order, and if the patient’s physician decides that the surrogate is not acting in the best interests of the patient, the physician may ethically and legally choose not to write the DNR/AND order. However, the surrogate should be advised that they may take steps to transfer the responsibility for the patient’s care to another physician.

4. When a physician believes it is necessary to consider a DNR/AND order for a patient without decision making capacity and no surrogate decision maker is available, he/she should initiate a multidisciplinary discussion about the patient’s resuscitation status with other physicians and staff involved in the patient’s care. This discussion should focus on the patient’s preferences (if known), the patient’s best interest, and the probability that CPR will benefit the patient. EJGH Legal Services should be contacted prior to writing DNR/AND in the medical record.

F. Temporary suspension of a DNR/AND order

1. If a patient with a DNR/AND order consents to an operation or procedure the DNR/AND order may be temporarily suspended for the procedure and the immediate post-operative period.

2. Suspending the DNR/AND order in this circumstance is justifiable in the event an arrest is the result of factors (such as anesthesia-induced cardiac arrest) other than the underlying illness, and when the arrest is easily and quickly reversible.
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3. The suspension of the order will begin at the time of induction of anesthesia and end whenever the patient has achieved post-operative stability, usually by the time the patient leaves the Post Anesthesia Care Unit.

4. Informed consent for the operation or procedure should include discussion of this possibility. The decision to suspend the DNR/AND order in such circumstances should be based upon a discussion with the patient/surrogate in advance of the procedure and documented in the medical record.

VI. REFERENCES:

JAMA. 1974; 227 (7) (Suppl.): 864.
JAMA. 2012; 307 (9): 917-918.
Living Will - Louisiana Statute 40: 1299.53.
Center to Advance Palliative Care website (capc.org) Accessed July 2013.
Living Will/Medical Power of Attorney; Admin, Policy LEG-06
Futile Care; Admin. Policy LEG-17
Resuscitation Code Status; Admin. Policy LEG-18

VII. APPROVAL:

Reviewed and approved by the Medical Executive Committee of the Medical Staff on January 14, 2014.