CENTER FOR PRACTICAL BIOETHICS
GUIDANCE AT THE CROSSROADS OF DECISION

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"The object of philosophy is the logical clarification of thoughts. Philosophy is not a theory but an activity."

- Ludwig Wittgenstein

Hot Topic: A Code Status Controversy

Helene Raynsford is a gold medal winning Paralympian. After surviving a severe brain injury in 2001, leaving her without the use of her legs, she took up rowing as a form of rehabilitation and quickly excelled in the sport. After competing at the 2006 Adaptive World Rowing Championship and the 2007 World Rowing Championship, she became the first ever rowing champion at the 2008 Beijing Paralympics.

Recently, Helene was prompted by her primary care network tomeet with a healthcare professional. During the meeting, she claims she was asked to sign a Do Not Resuscitate (DNR) form, and was troubled by the encounter:

I was quite frustrated about the whole thing. It made me feel not worthy. The only information this person knew was that I'm a wheelchair user... I don't have a life-limiting condition at the moment.

According to Helene, the person she spoke with was "not a trained healthcare worker." As a result, she feels discriminated against on the basis of her wheelchair use, and now feels "compelled to speak up to protect other disabled people."

Though there are important distinctions on the execution of DNR forms from state-to-state, Do-Not-Resuscitate orders provide guidance to medical providers on when *not* to engage in cardiopulmonary resuscitation (CPR). By default, the potentially life-saving intervention is enacted when a patient's heart stops or when they stop breathing, on the assumption that they would want it done and that there is a reasonable chance of it being effective. A physician's

order *not* to engage in resuscitative measures flips off the default switch. Writing a DNR (or DNAR—Do Not Attempt Resuscitation) requires a context of care in which *not* attempting to save a life is deemed appropriate.

What then are appropriate contexts for exploring a DNR order with a patient, given that most of us most of the time would want default resuscitation attempts in our own case? In particular, it would be morally dubious to assume that a DNR order is something desirable for every patient apparently disabled.

On the other hand, it is also suspect to assume that "Full Code" is desirable for everyone. Context matters.

Though we do not know of the circumstances under which Helene was asked to "sign a DNR," her concern raises important questions for Ethics. Other case situations that we either encounter or can imagine raise questions as well.

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Case Study:
When Clinicians and Surrogates Disagree

Diana is an 82-year-old, female-identifying patient. She presents to the ER after having suffered a head injury from a fall at home and losing consciousness.

Recently widowed, she is accompanied by her son, Michael, who informs the medical team that his mother has been living by herself for nearly three months. He lives thirty minutes from her. Michael tells the team that despite his incessant pleas to Diana that she move to a nursing facility, she has always declined. "Mom just doesn't want to leave home," he says.

Upon examination, it is learned that Diana has suffered traumatic brain injury and is unlikely to regain consciousness. What's more, she had previously exhibited signs of dementia and has a history of untreated diabetes and kidney failure.

Clinical Evaluation

Anthony, RN-APN, is one of the critical care nurses in the ICU where Diana has been admitted. On morning rounds, he asks the attending physician whether a Do Not Resuscitate order might be appropriate, given Diana's condition and prognosis. Anthony argues that "Diana won't benefit from CPR. She's probably never going to wake up and has numerous serious health conditions. The literature indicates CPR would do more harm than good, especially at her age and in her condition. It would just prolong her suffering and death. This patient ought to be DNR."

The attending agrees that a DNR order would make medical good sense. But despite the fact that it would be a physician's order, state statutes require that a patient or their representative must agree to withholding default resuscitation attempts—DNR—prior to a physician writing the order. Without this, a shift to "No Code" may be clinically correct but legally wrong.

Advising the Surrogate

Pam, the ICU team social worker, approaches the patient's son at his mother's bedside later that morning. She asks whether Diana has appointed someone to "speak on her behalf" medically, a "DPOA"? Michael says that he doesn't know anything about that. "But I'm her son. Isn't that good enough? If Mom can't make her own decisions, I'll do my best." The social worker makes a note of this conversation, which indicates the lack of a DPOA, but that the patient's son appears to be an appropriate family surrogate.

A bit later, the attending physician stops by also. He addresses Michael. "Your mother is seriously ill and is unlikely to regain consciousness. She is kept alive now by blood pressure medications and medically administered food and hydration. At some point, it is likely that she could stop breathing or that her heart would stop. If so, we could allow her to die peacefully, or we could try to shock her heart and intubate her to be placed on a breathing machine. Given your mother's condition and prognosis, it seems doubtful that doing those resuscitative measures would actually benefit Diana. If she is aware of anything—and we don't know that yet—doing CPR on her would definitely hurt. It would probably involve broken ribs, bruising, bleeding. And having a tube down one's windpipe with air blowing in and out has to be uncomfortable. What do you think your mom would want done?"

Surrogate Requests Full Code

Michael looks stunned. Uncomfortable by the question, he asks, “Well then aren’t you going to do anything for my mother? I think she wants to live, that’s what I think. Please do everything you can to save her. I just can’t let her go. Would you want your own mother to die if there was a chance of saving her?”

The physician explains again to Michael that Diana is not expected to regain consciousness; and even if she did wake up, the extensive brain damage cannot be repaired. Cognitively and in every other way, she will not be the same as before her fall. This, in combination with her age and frailty, makes CPR of questionable value to this patient. “Given your mother’s condition, chest compressions will likely harm her rather than help her,” says the doctor.

Michael however is now decided. He wants the ICU team to do everything they can to save his mom. “I’ve put my faith in a higher power,” he says. “I know she’ll come out of this. I’m sure of it. And even if she doesn’t get better, she’s still my mom so long as she’s alive. Being alive is all that matters.”

All of this is documented in the patient’s chart. “Son requests Full Code. Aggressive treatment.”

Moral Distress

In the ICU team’s huddle the next morning, a resident physician raises an objection. “Patients like this always code overnight or on the weekend when residents are covering. Do we really have to put the paddles on this lady, put a tube down her throat and break her ribs—all because her son “can’t let her go”? Can’t we find someone else to speak for her?” The young physician in training leaves the room. She is upset and frustrated; but so is everyone else. They all want what’s best for Diana and are convinced she shouldn’t be “full code” and that she wouldn’t want to be if she could speak for herself.

What is the medical team to do?

Ethical Musings:
Two Questions Regarding CPR

As Jonsen et. al (1992) noted more than 30 years ago, determining whether DNR orders (or other medical orders, like DNR-style orders or POLST and TPOPP forms) are appropriate in any given circumstance can be complex. Indeed, principles in bioethics must be factored in tandem with institutional policies, statutory legalities and clinical or other contextual realities.

Medical Futility and Quality of Life

When clinicians, their patients and/or families are contemplating code status, two somewhat controversial bioethics concepts often get mentioned: "medical futility" and "quality of life." The former refers to situations where some treatment or intervention almost certainly will be of no physiological benefit to the patient. It won't work. In such cases, there are no benefits to be weighed against the almost certain harms of contusions, broken ribs, or other CPR trauma experienced such as electrical shocks. In cases when the intervention does result in restoration of a heartbeat, perhaps with ventilator support of breathing, the patient may also endure prolonged death and suffering, yet still not leave the hospital alive. Diana's case may be of this sort. One would be right to wonder whether doing as her son requests would constitute medical futility despite probably good intent on his part.

Whether CPR could contribute to Diana's perceived quality of life is yet another matter. Determining this requires an understanding of the patient's goals of care as well as her healthcare preferences, which her medical team does not currently have access to. We can imagine a possible world, though, where we *do* know her goals of care, where Diana engaged in advance care planning discussions with her son, appointing him as a surrogate decision-maker and informing him about what she would or would not want done under conditions such as encountered now. In this possible world, she might have indicated wanting resuscitation attempts "if only for a chance to see her grandchildren one last time." Maybe she is the kind of person for whom an acceptable quality of life entails "fighting" the odds, whatever they are. Or, given the physicians' prognosis of medical futility in regard to CPR, more likely Diana would have stated a preference for being allowed a peaceful, relatively nontraumatic quality of life in her dying moments. Most of us likely would if we were to think about this in advance. In the case as written, and in real life for most Americans, healthcare preferences are *not* discussed in advance nor are they known at the time when it matters most.

In Cases of Disability

And then there is Helene Raynsford and her physician's presumptive DNR discussion, perhaps on grounds of disability discrimination. With only minimal information as provided by the patient and from her experience of that clinical encounter, ethics questions nonetheless are warranted. Why was she asked to sign a DNR order? Did the medical provider take CPR to be non-beneficial in her case? If so, why? What about her goals of care? After all, she doesn't

seem to have a life-limiting condition. What's more, she feels she deserves a fighting chance at life in an emergent scenario. She writes:

Is a judgment being made about the value of my life compared with someone else's life? Would this mean that if I was injured in a car crash my life would not be deemed worthy of saving?

More information would need to be ascertained to properly understand Helene's healthcare preferences. Given her statement above, it seems CPR comports with her goals of care. This should figure in her advance care planning and her medical provider could help her explore this possibility, rather than assume a DNR is appropriate in her situation.

Nonmaleficence and Justice

Principles in bioethics should also factor in DNR discussions. For purposes of this discussion, let's hone in on the principles of nonmaleficence and justice.

The former, also known as the "do no harm" principle, holds that medical providers have a moral obligation *not to harm* their patients. The latter holds that healthcare resources should be distributed fairly. Given these principles, we might say DNR orders should (a) be explored when they are expected to reduce harm to the patient, and (b) be discussed with anyone for whom CPR is deemed to be medically futile, no matter their race, gender or disability.

In other words, we could ask two questions: In what sense, if any, might resuscitation attempts benefit this patient or would it harm instead? Would CPR be appropriately just in this situation or unjustly traumatic and also wasteful of healthcare resources?

In the case study above, ICU caregivers are concerned that CPR will harm Diana by causing physiological trauma, such as breaking ribs, without physiological benefit. We might say they are committed to upholding the "do no harm" principle. In Helene's case, she feels she is unfairly being asked to forgo a medical intervention on the basis of wheelchair use. Helene notes that her provider made her feel like her "worthiness for treatment was being questioned." She writes:

I have on several occasions reminded people that my being a wheelchair user does not mean I should be subjected to exclusion, discrimination or unequal treatment.

More information must be gathered to understand the full context of Helene's

situation and the physician's perspective on what happened. It matters that Helene's experience was that of being treated unjustly by her provider. In any case, a wide-range of factors should be considered when exploring not only the medical appropriateness of the DNR order, but also the ethical appropriateness.

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