Making Sense of Bioethics
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Going Too Far with DNR?

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Resuscitating a patient who undergoes a cardiac arrest or stops breathing often involves multiple procedures. When a resuscitation "Code Blue" is called in the hospital (or on a TV show), something like a medical "flash mob" comes together to try to save the patient. The sequence of events typically involves a combination of CPR, airway assistance, medications and shocks to the heart when the resuscitation is performed in a clinical setting. Sometimes these interventions can seem unwarranted or extreme, and people wonder whether it would be OK to fill out a "Do Not Resuscitate" order (DNR) for themselves or for a family member. Would declining permission to resuscitate someone mean they are abandoning their loved one? Each crisis or emergency situation will have unique contours, and the question of our moral duty to provide resuscitation will vary with the details of each case. Sometimes a DNR order will be a reasonable choice; other times it will not.

If a DNR order is chosen, the condition of the patient must be such that the intervention would be of no significant benefit to him or her. Sometimes out of a generalized fear of medical technology, people may decide to put a DNR in place many years before any serious medical situation arises. Without knowing the medical particulars of their own future situations, however, this would be an unwise and ill-advised step. It can also be premature to decline a full code early in the course of a progressive disease, as resuscitation might well offer a bridge to healing or to another extended period of life. As the patient's condition worsens, though, he or she may later decide that a full code has become unreasonable, and choose a DNR at that point. These judgments are tricky to make, because the specifics of each case differ, and those specifics change with time and disease progression. DNR's should be put in place only when the circumstances warrant it, that is to say, on a case-by-case, patient-specific basis. In other words, when CPR/resuscitation can reasonably be determined to no longer offer a hope of benefit to the patient or if it entails an excessive burden to him, at that time a DNR can be put into place.

Some of the possible burdens that may need to be considered in deciding whether to pursue resuscitative interventions for a patient would include some of the following: the risk of rib or

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other bone fractures, puncture of the lungs by a broken bone (or from the trauma of lung compression and decompression), bleeding in the center of the chest, cerebral dysfunction or permanent brain damage, the small risk (about 3 or 4%) that the patient might end up entering a vegetative state, and subsequent complications if the patient ends up staying on a ventilator for an extended period following the resuscitation.

During resuscitative efforts, elderly patients are more likely to experience complications or to have ribs break during CPR. Younger patients, on the other hand, tend to show a greater resilience and are often better able to tolerate CPR. Patients suffering from advanced cancer are also known to fare poorly following resuscitative efforts.

In terms of overall statistics, when a patient codes in the hospital and all resuscitative measures are taken, patients frequently do not end up leaving the hospital, especially when they are elderly or have other co-accompanying conditions. Based on accumulated data from the National Registry of Cardiopulmonary Resuscitation (NRCPR), studies have determined that patients who undergo cardiac arrest in the hospital have an overall survival to discharge rate of about 17%. The rate drops even lower (to around 13%) for cancer patients. In other words, the benefits are oftentimes few and short-lived, while the burdens tend to be high. There are, of course, exceptions — while many patients do not experience significant benefits from resuscitative measures, a small percentage do.

So when death is imminent, and disease states are very advanced (perhaps with multiple organ failure), and assuming other spiritual matters, such as last sacraments, have been addressed, a DNR order may not raise any moral problems. The key consideration in making the judgement will be to determine whether the benefits of resuscitation outweigh the burdens.

DNR orders can be misused, of course, if they are broadly construed as calling on medical professionals to abandon or otherwise discontinue all care of a patient. Even as patients may be declining and dying of serious underlying illnesses, we must continue to care for them, support and comfort them, and use the various ordinary means that they may have been relying on, such as heart and blood pressure medications, diuretics, insulin, etc.

We should always seek to do what is ethically "ordinary" or "proportionate" in providing care for our loved ones, though we are never obligated to choose anything that would be heroic, disproportionate or unduly burdensome when it comes to CPR or other resuscitative measures.

Rev. Tadeusz Pacholczyk, Ph.D. earned his doctorate in neuroscience from Yale and did post-doctoral work at Harvard. He is a priest of the diocese of Fall River, MA, and serves as the Director of Education at The National Catholic Bioethics Center in Philadelphia. Father Tad writes a monthly column on timely life issues. From stem cell research to organ donation, abortion to euthanasia, he offers a clear and compelling analysis of modern bioethical questions, addressing issues we may confront at one time or another in our daily living. His column, entitled "Making Sense of Bioethics" is nationally syndicated in the U.S. to numerous diocesan newspapers, and has been reprinted by newspapers in England, Canada, Poland and Australia.