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Decoding Code Status: The Case of DNAR

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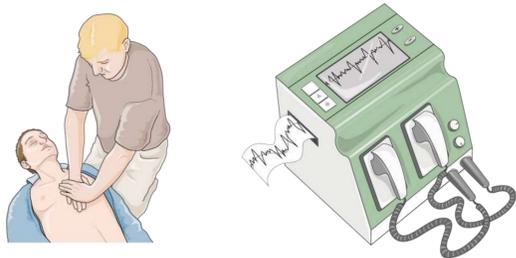
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Introduction

- Cardiopulmonary resuscitation (CPR) introduced in the 1960's led the American Medical Association to recommend reviewing code status with each patient
- Currently all hospitals across the country review code status with patients at admission
- A 'do not attempt resuscitation' (DNAR) code status means that a patient with decision making capacity (DMC) has indicated in the event of cardiopulmonary arrest, they do not want to receive chest compressions, assisted ventilation or defibrillation
- Usually DNAR is designated when no medical benefit is anticipated, where a poor quality of life is expected after CPR or where the quality of life was poor before CPR



Case

- We present the case of a 57-year-old-female with a past psychiatric history of bipolar disorder who was admitted to our inpatient psychiatric hospital for worsening depression, suicidal ideation and a plan to slit her wrists
- On admission, she denied current suicidal ideation but endorsed depressive symptoms of decreased energy and concentration, low mood, hopelessness, worthlessness, anhedonia and previous suicidal ideation just prior to arrival
- She had an extensive past psychiatric history including two previous suicide attempts, impulsivity, numerous inpatient hospitalizations, multiple medication trials, and significant childhood sexual and physical abuse – making her high risk for suicide
- In addition, she had multiple co-morbidities including uncontrolled type 2 diabetes, previous myocardial infarctions, coronary artery disease with previous coronary angioplasty and stenting
- She requested to be DNAR, articulating the risks and benefits, as well as, appreciating the consequences for her decision
- She reported having had previous myocardial infarctions requiring prolonged hospitalizations and she did not want to endure the pain and suffering associated with the procedures, treatment and extended hospital stays
- Our team was concerned for the motive behind patient's request, given her extensive psychiatric history, high risk for suicide and current depressive symptoms, and additionally what this meant if the patient was given DNAR but attempted suicide while admitted

The Question

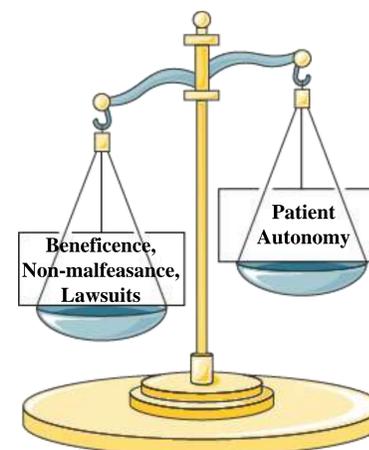
- To what extent should providers respect patient's autonomy of DNAR code status if there is suspected secondary motive, such as intent to die by suicide, or if their decision is impacted by an untreated psychiatric condition, like depression?

Ethical Discussion

Arguments against DNAR	Arguments for DNAR
<ul style="list-style-type: none"> • Most providers will lean towards the duty to preserve life 	<ul style="list-style-type: none"> • Others have argued that a sense of responsibility, compounded by guilt and fear of litigation, make providers quick to override DNAR requests, losing sight of the patient as a person and a narrative
<ul style="list-style-type: none"> • They will act for the good of their patient, and counter the individual's autonomous wishes expressed as a DNAR code request 	<ul style="list-style-type: none"> • It is important to determine if the DNAR request or order was part of the plan to commit suicide, or an independent and deliberate choice isolated from his or her impulsive decision or ideation to commit suicide
<ul style="list-style-type: none"> • The primary purpose of psychiatric hospitalization is to keep safe a patient who has the intent to harm themselves or others, and following a DNAR order would be counterproductive to this goal 	<ul style="list-style-type: none"> • Autonomy does not just apply to the ability to determine the course of one's life, but the course of one's death
<ul style="list-style-type: none"> • Providers intervene based on the assumption that a person suffering from a mental illness has impaired judgement. This assumption is usually correct, with 90% of suicides found on post-mortem psychological review to be associated with mental health such as depression, substance abuse or psychosis 	<ul style="list-style-type: none"> • Battin (1996) argues that suicide may help a person avoid what is feared more than death, a continued existence in a state he or she perceives as worse than death
<ul style="list-style-type: none"> • Additionally, the individual who has suicidal ideation is suffering from a treatable mental illness, and once effective treatment is provided the individual will no longer wish to commit suicide 	<ul style="list-style-type: none"> • It is reported that it may be appropriate for a depressed patient to take action or pursue inaction to end his or her life. If a person suffers from a terrible, incapacitating, untreatable and debilitating mental disorder that robs him or her of the ability to function, how is that fundamentally different from a medical or physical disorder that does so?

Legal Discussion

- In the context of suicide attempt or ideation, most providers will be strongly motivated to override DNAR orders or requests to avoid malpractice lawsuits for suicide
- However, legally this may make them vulnerable to legal claims on battery, including a failure to obtain a patient's informed consent, or damages of "wrongful living" or "wrongful prolongation of life"
- These claims argue there was a failure to respect the autonomous rights of a patient who has exercised these through weighed choices and made a particular end-of-life care decision, and that the injury of living beyond that desired length should be compensable



Clinical Discussion

- The general consensus among providers is that an individual suffering from a mental illness on the inpatient unit, lacks the capacity to make decisions
- Depressed patients often feel hopeless and apathetic, inaccurately weighing the benefits of treatment or have inappropriate guilt of being a burden to their family, fueling DNAR requests
- Some argue the capacity determination of DNAR orders is highly contextual and should be considered against the backdrop of a patient's entire life, repeated conversations, and the patient's philosophy of life
- It is crucial if there is a difference in timing of a suicide attempt or ideation, and constancy of the intent for DNAR
- Data from the MacArthur Treatment Competence Study concluded that about three-fourths of patients hospitalized for depression performed well on all measures of decision-making competence
- Mentally ill persons can make decisions if they show they have capacity to understand them sufficiently, the alternatives and consequences
- A person can state that just living with their illness is terrible and they would never want to extend life in their unremitting mental illness state –
 - This does not necessarily mean that they will do active things to encourage death
 - However, only to make sure no unusually aggressive measures such as CPR/intubation are performed which might prolong suffering
- The presence of a terminal illness and associated suffering should be considered as a possible alternative to mental illness as a motivation for suicide attempt

Conclusion

- Having clear hospital policies regarding honoring DNAR orders if a patient has a history of suicidal ideation, attempts or both
- DNAR orders do not transfer between different facilities, all teams should address and discuss with the patient their preferences and wishes upon admission
- A policy for "required reconsideration" can be investigated and should be the forefront of this discussion
 - Such as in the case of the operating room, DNAR patients are temporarily changed to full code status for the duration of a surgery and post-operative care
- Required reconsideration policies could outline specific situations in which DNAR should and should not be enforced, such as in the case of a suicidal patient or one expressing previous suicidal ideation just prior to admission
- Each situation is different, though the discussion with the patient remains the key foundation in addressing this issue, to take into account a patient's unique narrative

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