DNR — A God-Like Decision

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In his book Come, Let Us Play God Augenstein states, “There are times when we have to make God-like decisions” (1). Not to resuscitate a patient who is regarded as terminally and irreversibly ill, for whom resuscitation is considered futile, might be classified as a decision requiring divine qualifications. However God-like it may be, a decision often needs to be made on whether or not to “code” a patient, hoping to write an order that is consistent with the highest tradition of good medical practice and in the best interests of the patient, the family, and society.

The experience of Redmond and Ahmad (2) recounted in this issue illustrates the dilemma facing physicians who care for the critically ill. Having suffered a pontine stroke, this patient rapidly developed the profound neurologic disturbances that characterize patients whose reported course has been uniformly fatal. The present patient, however, responded to supportive measures in the intensive care unit and was ultimately restored to independent living. Although the possibility of discontinuing resuscitative efforts was never a consideration in this case, the patient’s course does demonstrate that ominous physical deterioration may be unexpectedly reversed.

Writing on medical ethics, Haring stated: “An expensive treatment for a life already doomed may constitute a grave injustice toward the members of the patient’s family. Often the heavy financial burden is incurred by the family solely through fear for their reputation. The attending physician would be acting irresponsibly were he or she to yield to family pressures in such a case” (3). Pius XII long ago spoke in an approving tone about families who bring pressure to bear upon the attending physician “to remove the respirators so as to allow the patient, already dead, to depart in peace” (4). Medical progress must not deny a person his ethical right to die in human dignity (5).

A Special Biomedical Ethics Committee for the American Hospital Association considers three essentials to making a decision not to resuscitate (DNR). They are: 1) maximum medical data; 2) preferences of the patient, interpreted if necessary by the patient’s family or other surrogate; and 3) consultation among physicians, other attending health care professionals, and family members. The Committee insisted that a DNR order should never be written without the knowledge of the competent patient or the family or surrogate of the patient (6).

From a theological perspective, physicians and ethicists may have a different emphasis in their approach to the dying, but there need not be any radical disagreement between them, if three truths are clearly understood:

1. Physicians and moralists often use the terms “ordinary means” and “extraordinary means” with different connotations.
2. While the physician has the expertise and the right to make decisions concerning the usefulness or medical effects of given therapeutic measures, the patient (and/or the family of the patient) has the right to determine whether those measures are ordinary or extraordinary from an ethical point of view.
3. If the measures are determined to be ordinary, then they must be employed; if extraordinary, they may be employed. The decision should be made by the patient (and/or the family) in consultation with the physician. Whatever the decision, ordinary care should continue (7).

When technology is used to save lives, no one questions its benefits. But when it is used to prolong a person’s dying and to add to the burden faced by the individual, the family, society, and the medical staff as well, there is a growing consensus among religious leaders that withholding “last-gasp” measures is justified. The following statements in support of such a position are from seven major religious denominations:

We have a moral obligation to protect life. When our resources are inadequate to secure the continuance of life, we need to allow the patient to proceed to the next stage of life that begins with death (Lutheran Church).

When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life (Pope John Paul II).

The removal of pain and consciousness by the means of drugs, when medical reasons suggest it, is permitted by religion and morality to both doctor and patient, even if the use of drugs will shorten life (Pope Pius XII).

The conclusion from the spirit of Jewish law is that while you may not do anything to hasten death, you may, under special circumstances of suffering and helplessness, allow death to come (Central Conference of American Rabbis).

We assert the right of every person to die in dignity without efforts to prolong terminal illnesses merely because the technology is available to do so (United Methodist Church).

When illness takes away those abilities we associate with full personhood, we may feel that the mere continuance of the body by machine or drugs is a violation of their person . . . We do not believe simply the continuance of mere physical existence is either morally defensive or socially desirable or is God’s will (United Church of Christ).

We believe that human life is a gift that is meaningful only as long as the receiver is able to function as a person (American Friends Service Committee).

We support euthanasia (defined as the refusal to take extraordinary means to preserve life) when one has been reduced to a vegetative existence or is dying of an incurable disease with unrelied suffering (Presbytery of New York City).
Whatever guidelines are adopted on DNR today, they will need review tomorrow. Concepts change with new insights and advances in medical technology. What is considered extraordinary today may be ordinary tomorrow. As long as we are alert and open to modification and change in maintaining high standards of medical practice, we are on the right track.

Guidelines for issuing the DNR order as well as those for the determination of death have been formulated by a specially convened committee of Henry Ford Hospital. After broad consideration and modification, the recommendations have been adopted as policy by the Board of Governors. Application of these guidelines can help physicians make their God-like decision, but human beings can never escape the possibility of human error.

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References