Balancing Patient Autonomy, Surrogate Decision Making, and Physician Non-Maleficence When Considering Do-Not-Resuscitate Orders: An Ethics Case Analysis

NABIL MEHTA, BSE; SAMANTHA ROCHE, BS, MPH; ELISABETH WONG, BA; ABASS NOOR, MD; KATHRYN DECARLI, MD, MBE

CASE SUMMARY

Ms. Smith, a 64-year-old woman, presented to her PCP with diffuse abdominal pain, nausea, and constipation. She had a history of chronic lower back pain and multiple back surgeries for which she had an implanted intrathecal morphine pump. She was referred to the hospital for an esophagogastroduodenoscopy and colonoscopy, both of which were unrevealing. After the procedures, Ms. Smith felt "miserable" and lethargic and was subsequently admitted to the hospital for observation. The admitting physicians verbally confirmed her code status as DNR/DNI.

The next morning, a nurse reported that Ms. Smith had been complaining of severe headache and leg shaking. Around 7 a.m., Ms. Smith was discovered unresponsive in her bed. She responded to naloxone and sat bolt upright, confused and agitated, swinging her arms and attempting to escape the bed. Given this vigorous response to naloxone, the team considered opiate overdose from a malfunctioning morphine pump as a potential etiology for the event. However, given the possibility of an intracranial hemorrhage or stroke, an urgent head CT was deemed necessary. It was clear that having the patient remain still for the scan would be a difficult task, especially as her combativeness persisted after receiving 2 mg of lorazepam. The team was hesitant to give more benzodiazepines in the setting of potential opiate overdose, especially since the patient's code status was DNR/DNI and she could not be intubated if needed.

After reviewing the chart, the attending physician found it unusual that such a relatively healthy, young woman was not Full Code and explored this with Ms. Smith's husband, her medical power of attorney. Mr. Smith explained that his wife had filled out an advanced directive with her PCP, delineating her wishes to be DNR/DNI, but that the document was at home. After a discussion of the implications of the DNR/DNI status, the husband clarified that Ms. Smith would want life-saving measures if there were a reasonable chance of recovery.

After the husband's explanation of his wife's wishes and despite the presence of an advanced directive, the team decided to change the patient's code status to Full Code to allow more leeway in administering additional medications with the potential to cause respiratory suppression in the workup of this unresponsive episode. In this case, giving additional lorazepam could potentially be life-saving if the CT showed a brain hemorrhage. On the other hand, the patient was clear in her DNR/DNI status prior to admission and had written documents expressing these wishes.

MEDICAL STUDENTS' ETHICS ANALYSIS (EW, SR, NM)

As Ms. Smith's case demonstrates, despite tools such as advanced directives and powers of attorney, it remains difficult for patients to achieve prospective autonomy in regards to future care. This results in myriad ethical dilemmas. Many patients with DNR/DNI orders have conflicting wishes when queried with hypothetical scenarios. Additionally, medical details are impossible to predict which makes directives misleading and difficult to adapt.[2] Therefore, would it have been ethical to carry out Ms. Smith's advanced directive since it was inflexible and presupposed unrealistic understanding on the patient's part? Surrogate decision makers offer a plausible alternative since they can adapt to new details and information while keeping the patient's values and wishes in mind. However, surrogate decision makers frequently make choices that do not align with what the patient would have decided in the same situation.[3,4] Given this, was it ethical for Ms. Smith's husband to change her code status in the face of her acute condition and the need for potentially life-saving sedation? How should the balance between patient autonomy and physician non-maleficence be approached? To explore this dilemma, we consider the history and evolution of ethical issues related to DNR/DNI orders.

DNR orders were originally intended to restrict use of CPR for patients who had decided that the potential harms of resuscitation outweighed the potential benefits.[5] Primarily, these patients were nearing the ends of their lives, due to age or irreversible illness. As DNR orders became more common, many patients who did not wish to undergo CPR still chose to undergo procedures, including those requiring anesthesia or sedation, often for palliative purposes.[6] This created undeniable discomfort, particularly for anesthesiologists tasked with balancing the goal of achieving analgesia/amnesia against the potential for cardiovascular collapse inherent in administering anesthesia/sedation.[6] Subsequently, many anesthesiologists assumed the DNR order to be suspended during surgery, and this assumption was often made without the patient's knowledge or input.[7]

Despite being employed by many organizations, the policy of automatically suspending DNR orders poses many ethical (and legal) issues, and certainly violates the principle of a patient's right to autonomy.[8] Of course, that is not to say that DNR orders should never be suspended.

On the role of DNR orders in surgery, Truog offered several reasons that may ethically justify suspending a DNR order in cases requiring anesthesia/sedation.[6] First, administering anesthesia/sedatives by nature involves the purposeful depression of vital functions followed by a skillfully planned "resuscitation"; therefore, any consent for anesthesia implies consent for the necessary resuscitation. Second, spontaneous cardiac arrest is notably different from an arrest that occurs "as the result of a therapeutic intervention" (i.e., respiratory depression from a drug overdose), as the latter is significantly more likely to be reversible.[6] We posit that these conditions applied to the administration of sedatives in the case of Ms. Smith, making it ethically defensible to suspend her code status for sedating her to obtain emergent diagnostic imaging.

Since the inception of DNR orders, conventions for physicians around respecting these orders have undergone substantial change. One approach towards a more ethical use of DNR orders has been for physicians to adopt a "procedural approach" to determining patients' preferences, perhaps recording specifically that a patient does not want ICU care or endotracheal intubation, for example.[7] An alternative "goal-directed approach" has been suggested, in which discussions of the patient's goals, values, and fears are used to inform the physician's decision of which procedures should be performed under which circumstances in real time.[9] This approach is accompanied by several challenges, perhaps the most significant of which is that it requires the clinicians making the decisions to have a nuanced knowledge of the patient's wishes. However, a goal-direct approach recognizes that it is impossible to represent the full range of scenarios that may arise over the course of care, particularly when anesthesia and sedation are involved, and offers the best opportunity for the patient to experience their desired outcome.

ETHICS COMMITTEE ANALYSIS (AN, KDEC)

There are multiple options in this scenario: (1) treat the patient for suspected morphine overdose and do not obtain head CT, (2) administer medications needed to obtain head CT; if this results in respiratory compromise, proceed to intubation, (3) administer medications needed to obtain head CT; if this results in respiratory compromise, do not proceed to intubation.

If this patient's code status is an accurate reflection of her wishes, then it is not appropriate for the care team to place her in a position that risks need for intubation (option #3). Options #1 and #2 are both ethically consistent; the challenge lies in clarifying her wishes. The medical team's bias towards a Full Code status for this relatively young and healthy patient has no bearing on her autonomy to refuse intubation. However, there is compelling information to suggest the patient's code status is not consistent with her actual wishes. Because she is unable to convey her wishes, we must rely on prior documentation, reach out to her PCP, and seek interpretation from her surrogate decision-maker.

The literature sets precedent that code status should not dictate care, but rather inform exploration with the health care proxy of specific medical situations. The spouse's willingness for this patient to be intubated should be taken into account because "research suggests that many patients do not expect surrogates to rigidly follow their traditional advance directives, but rather intend for surrogates to exercise judgment to determine the course of care when there is insufficient information available or for extenuating circumstances."[10] Silveira et al suggest we must "accept surrogate decisions as valid expressions of the patient's autonomy, even when those decisions conflict with the patient's written preferences."[11]

The PCP should play an important role in advanced care planning. Resources such as The Conversation Project[12] offer tools to achieve the widely called for goal "to transform advance care planning from the act of signing a form to a process."[13] However, plan as we may, "no prior discussion or documentation can anticipate all scenarios."[14] It is unreasonable to assume that this patient thought through the present case when she made her wishes known – but it is still possible she may have considered similar circumstances. If her spouse feels confident that she would accept possible intubation in this instance, it is reasonable for the medical team to move forward with CT scan, even if anesthesia is needed, and proceed to intubation should that become necessary.

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Acknowledgment

The first three authors contributed equally to this work.

Authors

Nabil Mehta, BSE; Alpert Medical School of Brown University, Providence, RI.

Samantha Roche, BS, MPH; Alpert Medical School of Brown University, Providence, RI.

Elisabeth Wong, BA; Alpert Medical School of Brown University, Providence, RI.

Abass Noor, MD; Alpert Medical School of Brown University, Providence, RI.

Kathryn DeCarli, MD, MBE; Resident, Department of Medicine, Alpert Medical School of Brown University, Providence, RI.

Correspondence

Elisabeth Wong
Alpert Medical School of Brown University
222 Richmond Street
Providence, RI 02903
Elisabeth_wong@brown.edu