

## Summary of Ethics for Lunch – October 19, 2021

### Attending and Resident Physician Involvement in DNR Discussions

Moderator: Mark T. Hughes, MD, MA

Panelists: Stephen A. Berry, MD, PhD; Brent Petty, MD; Caitlin McGeehan, RN, BSN, CCRN; Meghan Stepanek, Esq., MPH, Kathleen Hiltz, MD

The October Ethics for Lunch discussed the hospital policy on “Do Not Attempt Resuscitation Orders” and specifically the requirement for a resident physician to discuss these orders with the attending physician. Key points from the panel discussion:

1. Cardiopulmonary arrest is the cessation of cardiac and respiratory function, resulting in loss of effective blood circulation and breathing.
2. Cardiopulmonary resuscitation (CPR) is an emergency procedure in which the heart and lungs are made to work by manually compressing the chest overlying the heart and forcing air into the lungs.
3. A Do Not Resuscitate (DNR) Order (or more properly Do Not Attempt Resuscitation (DNAR) Order) is a medical order to withhold cardiopulmonary resuscitation in the event of a cardiac or respiratory arrest.
4. Maryland Medical Orders for Life Sustaining Treatment (MOLST) include orders for performing or withholding CPR.
5. MOLST forms can be signed by a physician, nurse practitioner, or physician assistant. In 2013, the Department of Health and Mental hygiene indicated that unlicensed resident physicians could sign MOLST forms while performing their assigned duties.
6. In the Johns Hopkins Hospital policy on DNAR, the attending physician can delegate authority to resident physicians to discuss CPR/DNAR with patients and authorized decision makers but DNAR orders must be co-signed by the attending physician.
7. The discussion that a resident has with a patient or authorized decision maker about CPR (“code status”) must be documented in the medical record and the attending physician has responsibility to confirm the decision maker’s wishes and review these orders throughout the hospitalization.
8. The Health Care Decisions Act provides guidance to clinicians in how to make decisions about life-sustaining treatment with patients or authorized decision makers. The attorney general has provided opinions about how to apply the Act in particular clinical situations.
9. The attorney general opinion letter of May 3, 1994 discussed application of the Health Care Decisions Act to “Do Not Resuscitate” Orders and noted:
  - a. For patients in whom it is anticipated that cardiac arrest is a significant risk, the clinician should obtain informed consent about CPR to know, in advance, if the patient wishes contingency plans to be made if cardiac arrest occurs. This is especially important for patients in whom a decision against the use of CPR would not be unreasonable.
  - b. A health care agent has broad authority to make decisions on behalf of the patient, including a DNAR order and other decisions to withhold or withdraw life-sustaining treatment.
  - c. A guardian of the patient must obtain authority from the court to make decisions about life-sustaining treatments.
  - d. A surrogate decision maker (who is not a health care agent or guardian) may decline life-sustaining treatment only if the patient is certified to be in a terminal condition,

persistent vegetative state, or end-stage condition, unless two physicians concur that the event of cardiac arrest itself would signify that, at that future time, the patient would be in a terminal or end-stage condition. A surrogate's decision for DNR must be in accord with the patient's wishes and if these wishes are not known, then on the patient's best interest.

10. The panelists were asked to comment on cases in which the attending was not immediately available:
  - a. A patient with capacity who has an established MOLST indicating DNR/DNI and confirms this with the admitting resident. The resident would place the order and, provided the patient is not expected to clinically decompensate, would discuss this with the attending physician during morning rounds.
  - b. A patient desiring "Full code" status indicates they have an advance directive. The nursing admission intake asks whether a patient has an advance directive, although it may not be a typical part of the resident physician's admission process. The nurse would encourage the patient to provide a copy of the advance directive so it is available to future clinicians if it becomes available in the future.
  - c. A patient lacking decision making capacity admitted from a nursing home with a MOLST order in which the accuracy cannot be confirmed with the patient. The MOLST is active until changed, but additional efforts may be needed to revisit the decisions, especially if the patient's condition has changed since the original MOLST form was signed.
  - d. A patient with decision making capacity is admitted for a surgical procedure and opts to change her code status from DNAR to Full code. The patient can void their MOLST.
  - e. A patient with decision making capacity is admitted with a hip fracture needing surgery requests a DNAR order on admission. This would require further discussion and making sure the patient has all the information they need to make a decision. This should also prompt a discussion with the attending physician to understand the patient's reasons for making the change.
  - f. A patient with an acute condition who is currently stable decides on DNR. There are pros and cons to having to notify the attending physician in real time.
  - g. A patient who has been officially deemed to lack decision making capacity has a health care agent who requests DNAR/DNI. The health care agent has authority to make this decision. The policy expectation is that the attending would be notified of this decision, especially if the patient is unstable.
  - h. A patient tells a palliative care nurse he wishes to be DNAR. The nurse should make sure the patient has prognostic awareness and explore his values as they relate to the code status. The nurse can then be a catalyst to make sure the clinicians on the primary service (including the attending of record) speak with the patient about his wishes.
11. Discussing code status is a clinical skill that is learned over time, and attending physicians should guide trainees in the proper way to conduct these important conversations with patients and authorized decision makers.