

Improving Do-Not-Resuscitate Discussions:

A Framework for Physicians

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Framing the DNR Discussion

Having DNR (do-not-resuscitate) discussions with patients and their surrogates is a challenging task. In discussing DNR orders, physicians struggle with two related challenges.

1. How should they frame the discussion so that patients and surrogates understand the medical situation, including the benefits and burdens of their decisions?
2. To what extent is it appropriate to make recommendations?

To make such discussions more constructive, we provide a framework that stratifies patients into three general groups (see Figure 1).

Cardiac Arrest as the Mechanism of Death

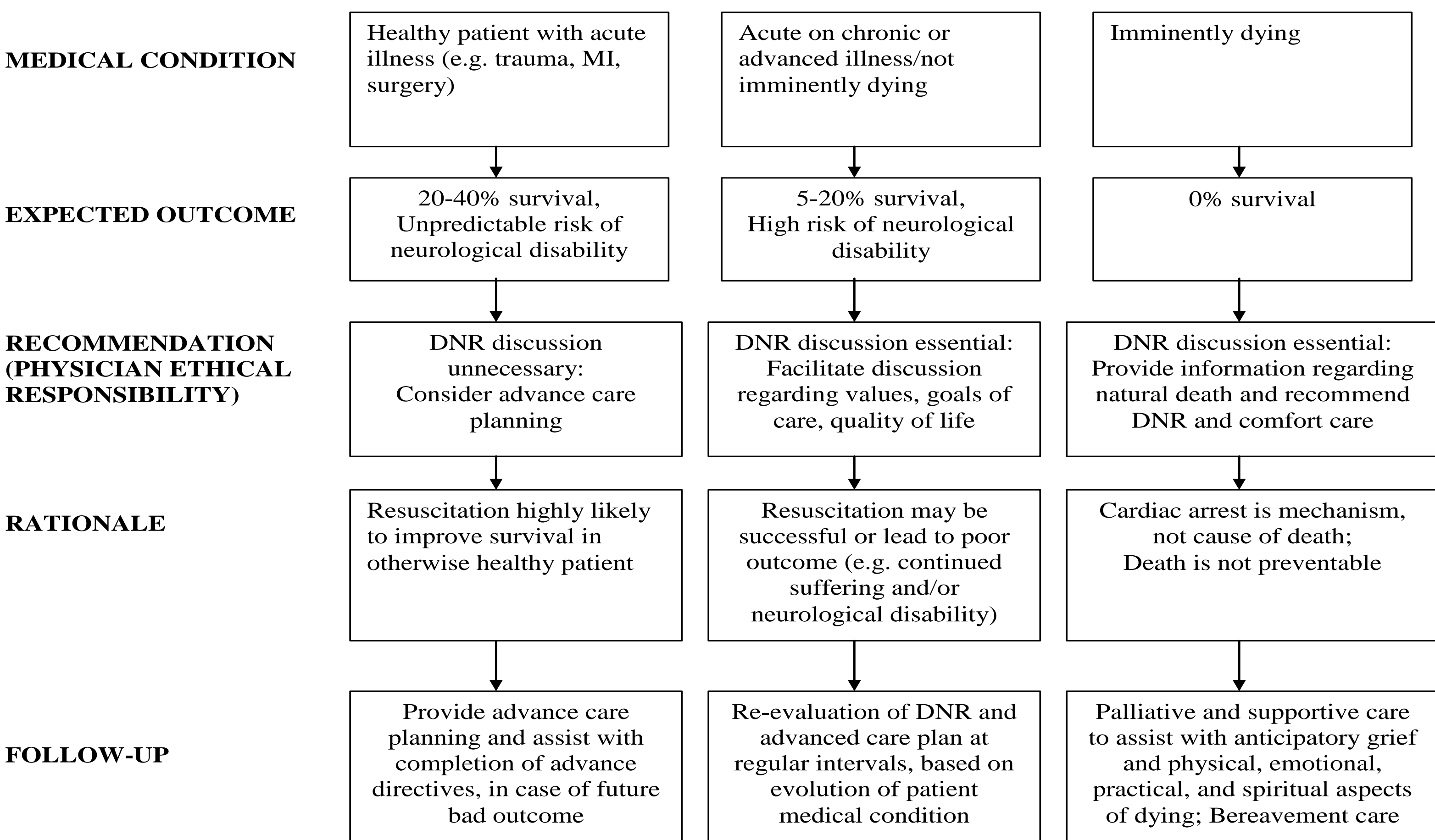
Although it is often difficult to determine the exact moment when a terminally ill patient crosses the line from seriously ill to imminently dying, once the line is crossed, the imminence of death becomes progressively more apparent to the experienced physician.

When an imminently dying patient dies, the final event will be a cardiac arrest; cardiac arrest is the mechanism of death, not the cause of death.

Efforts at resuscitation do nothing to treat the underlying cause of death, which remains inevitable and imminent. For this group of patients, the concept of “allow a natural death” is most applicable.

Stratifying Patients to Aid Decision-Making

Figure 1. Stratification to aid physician decision-making regarding DNR discussions and advance care planning



Following a Standardized “Script”

“Unfortunately, because we cannot treat your underlying disease, it will soon cause your death. When that happens, your heart will stop beating. Therefore, I would recommend that, when your heart stops, we focus on assuring that you die peacefully and comfortably, rather than using shocks and machines to try to restart your heart. Does that make sense to you?”

Avoiding the “Illusion of Choice”

Although a discussion of DNR orders with a **dying patient** (or surrogate) is mandatory, it should be framed in a way that makes the realities clear while being as gentle and supportive as possible. The goal should be both to inform the patient (or surrogate) and to assure that the best and most appropriate care is provided at the end of life.

To offer the patient or surrogate the “option” of resuscitation is to create a false impression that death is preventable.

Indeed, the illusion of choice—of “electing” a DNR order—when DNR is the only appropriate medical option, places an undue burden on surrogates, conveying a sense of responsibility and creating unwarranted feelings of guilt for their loved one’s death.

In situations where there is only one reasonable approach to medical care, physicians have an obligation to convey their recommendations clearly to a patient or surrogate; this approach does not impose one’s values on a patient, rather it fulfills one’s professional duties.

Conclusion

Stratifying patients into three groups (ranging from basically healthy to having an advanced or chronic illness to imminent death) provides a framework for the discussion of DNR orders. It helps to clarify the relationship between medical considerations and patient values and goals. Furthermore, it may improve patient and surrogate understanding and help physicians to provide guidance, thereby reducing patient and surrogate distress.