



Experience with a hospital policy on not offering cardiopulmonary resuscitation when believed more harmful than beneficial



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ABSTRACT

Purpose: This study investigated the impact of age, race, and functional status on decisions not to offer cardiopulmonary resuscitation (CPR) despite patient or surrogate requests that CPR be performed.

Methods: This was a retrospective cohort study of all ethics committee consultations between 2007 and 2013 at a large academic hospital with a not offering CPR policy.

Results: There were 134 cases of disagreement over whether to provide CPR. In 45 cases (33.6%), the patient or surrogate agreed to a do-not-resuscitate (DNR) order after initial ethics consultation. In 67 (75.3%) of the remaining 89 cases, the ethics committee recommended not offering CPR. In the other 22 (24.7%) cases, the ethics committee recommended offering CPR. There was no significant relationship between age, race, or functional status and the recommendation not to offer CPR. Patients who were not offered CPR were more likely to be critically ill (61.2% vs 18.2%, $P < .001$). The 90-day mortality rate among patients who were not offered CPR was 90.2%.

Conclusions: There was no association between age, race, or functional status and the decision not to offer CPR made in consultation with an ethics committee. Orders to withhold CPR were more common among critically ill patients.

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1. Introduction

Clinicians sometimes believe that invasive life-sustaining treatments such as cardiopulmonary resuscitation (CPR) should not be used despite patient or surrogate demands [1]. Many institutions have unilateral do-not-resuscitate (DNR) policies, which allow clinicians to withhold CPR in the event of cardiopulmonary arrest against the wishes of patients or their surrogates [2]. Some of these policies allow physicians to discontinue CPR only if it is unsuccessful after several minutes [3]. Others allow unilateral DNR orders prior to cardiopulmonary arrest, often contingent on the involvement of an interdisciplinary ethics consultation team [4]. Hospitals and critical care societies have expressed growing interest in these policies as a mechanism for protecting critically ill patients on an irreversible trajectory from unnecessary harm [5,6].

These policies are based on the principle of nonmaleficence: if CPR will cause harm without bringing meaningful benefit in the context of

the patient's values and prognosis, physicians should not offer it [7–10]. Other justifications for unilateral DNR orders focus on preserving professional integrity despite inappropriate surrogate demands, maintaining the dignity of dying patients, and the injustice of consuming limited resources for those who will not benefit from them [11–14]. Some bioethicists, however, have suggested that allowing clinicians to decide what constitutes a meaningful benefit or a dignified death represents unwarranted medical paternalism [15–18]. Critics have also argued that, given the way that age, race, and disability may impact clinician decision making in other areas, unilateral DNR orders may be disproportionately applied to vulnerable populations [19–27].

There are few studies on the use of unilateral DNR orders that address this last concern. Two cohort studies from the 1980s found that DNR orders were made without patient or surrogate consent in 4.4% of the general hospital population and in 27.4% of the cases referred to an ethics committee but did not examine demographic characteristics associated with these orders [28,29]. In 1988, Brennan [29] found that patients with unilateral DNR orders were younger and sicker than those with DNR orders made with surrogate consent. He did not, however, compare cases in which a unilateral DNR order was considered and not implemented to cases in which it was implemented. In 1999, Casarett and Siegler [30] found that 7 (22.6%) of 31 ethics consultations

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involving conflict over DNR status resulted in a unilateral DNR order. They found no association between unilateral DNR orders and race or age, but the study was not powered to detect these differences. There are no other studies that address whether policies empowering physicians not to offer CPR are disproportionately used in the elderly, the disabled, or nonwhites. If, however, unilateral DNR orders are more common in these populations, an ethical presumption against their use should be considered.

In 2006, Massachusetts General Hospital (MGH) revised its Life Sustaining Treatment Policy to state that physicians “are not obligated to offer or provide life-sustaining treatments that have no clinical indication or have no reasonable likelihood of providing benefit to the patient in the context of his or her values and prognosis.” Specifically regarding CPR, “the physician is encouraged to consider protecting an imminently dying patient from the potential harms of cardiopulmonary resuscitation by suggesting this protection to the patient or surrogate or by not offering CPR if it is not deemed to be a reasonable treatment option.” (Table 1). In this way, the policy provided a mechanism for not offering CPR when physicians believed that it was not a reasonable treatment option. The policy recommended that the MGH clinical ethics committee, known as the Edwin H. Cassem Optimum Care Committee (OCC), be consulted to resolve conflict over whether to provide CPR. Using data from OCC consultation and patient medical records, we investigated whether age, race, or functional status predicted the ethics committee recommendation not to offer CPR.

2. Materials and methods

2.1. Consultation process

Any health professional, patient, or surrogate may consult the OCC. Members of the OCC are trained in accordance with the American Society of Bioethics and Humanities Education Guide and are mentored by senior members of the committee to complete specific core clinical ethics competency objectives. A team of 2 or 3 OCC members, led by a senior consultant, typically responds to consultation requests. When asked to resolve conflict over DNR status, consultants attempt to determine the following: patient's prognosis, values, treatment preferences, and understanding of his or her illness; the conflicts that led to OCC consultation; and, what, if any, goals of care have been identified and agreed upon. Consultants provide an ethical analysis and make recommendations that are entered into the medical record, including whether CPR should be offered in cases of persistent conflict. As part of this process, the ethics consultants meet with members of the health care team and may propose and attend a surrogate-team meeting. Some consultations, however, are provided to the team alone. In all cases in which the

Table 1
Massachusetts General Hospital policies and procedures: life-sustaining treatment policy

Section 2.1.1

Physicians and other health care providers are not obligated to offer or provide life-sustaining treatments that have no clinical indication or have no reasonable likelihood of providing benefit to the patient, or more benefit than harm, in the context of his or her values, prognosis, and agreed-upon treatment goals.

Section 2.5.8

Doing no harm: the responsible physician always has an overriding responsibility to protect the patient from harm. The physician is encouraged to consider protecting an imminently dying patient from potential harms of CPR by suggesting this protection to the patient or surrogate or by not offering CPR if it is not deemed to be a responsible treatment option and by entering appropriate code status orders. The responsible physician may obtain a second opinion about not offering CPR from another senior or experienced physician or from the Optimal Care Committee [clinical ethics consultation committee] and may also request advice from the Office of General Counsel. If the responsible physician decides not to offer CPR, the patient or surrogate should be informed of this decision and its rationale and assured that the patient will continue to receive the highest possible quality of care.

OCC recommends not offering CPR, however, the patient/surrogate is informed of the decision and its rationale.

2.2. Optimum Care Committee consultation cohort

We reviewed all OCC consultations from 2007 to 2013 and included those involving disagreement between health care providers and patients or surrogates about whether to provide CPR in the event of cardiopulmonary arrest. We excluded cases in which consultation was for reasons other than conflict over DNR status and those in which the patient died before consultation was complete. When the OCC was consulted more than once for the same patient, we included only the consultation resulting in a final recommendation about offering CPR.

We obtained sociodemographic and clinical data from OCC consultation and MGH medical records. Sociodemographic variables including age, sex, race, insurance status, and primary language were self-reported by patients or surrogates upon admission to the hospital. Functional status prior to admission was categorized as complete independence, partial dependence, or complete dependence based on the patient's ability to carry all, some, or none of the basic activities of daily living [31]. Illness severity was defined by the patient's primary team at the time of consultation and was taken from the American Hospital Association categories of medical condition. These included good condition, vital signs are in normal limits and prognosis is excellent; fair condition, vital signs are stable and prognosis is favorable; serious condition, vital signs are unstable and prognosis is questionable; and critical condition, vital signs are significantly abnormal and prognosis is unfavorable. Decision-making capacity at the time of consultation was determined by the patient's primary team. The OCC consultants assessed level of alertness as alert or not alert.

One nonblinded author (E.R.) abstracted and coded all information about the content and outcomes of each consultation (Pearson correlation coefficient for intraobserver variability = 0.95). A second nonblinded author (A.C.) confirmed OCC recommendations and patient disposition. Study data were collected and managed using REDCap, an electronic data capture tool hosted at MGH. The institutional review board at MGH approved the study.

2.3. Statistical analysis

We used 2-tailed Student *t* tests and Fisher exact tests to compare continuous and categorical variables in 2 populations. First, we compared cases in which patients or surrogates did and did not agree with DNR status after initial OCC consultation. Second, we compared cases in which the OCC did and did not recommend withholding CPR.

3. Results

3.1. Study cohort characteristics

Between 2007 and 2013, there were 286662 adult admissions to MGH. There were 315 OCC consultations during this time, of which 134 involved disagreement about whether to provide CPR in the event of cardiopulmonary arrest (Figure). The characteristics of the included patients are listed in Table 2. Their average age was 67.4 ± 18.8 years, they were 38.8% nonwhite, and 79.1% were completely or partially dependent prior to admission. In 53.4% of cases, their health care providers judged them to be critically ill. In 92.5% of cases, the patient's surrogate requested that CPR be performed in the event of cardiopulmonary arrest. In 7.5% of cases, the patient made this request.

Compared with patients who were excluded from the final cohort ($n = 181$), patients for whom there was conflict over DNR status were older (67.4 ± 18.8 years vs 62.5 ± 20.0 years, $P = .03$; Table 3). They were also more likely to be nonwhite (38.8% vs 22.6%, $P = .003$) and to have been completely or partially dependent prior to admission (79.1% vs 60.8%, $P < .001$).

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