



How you want to be treated.



Introduction to the DNAR/Options for Care
Policy Framework

Respecting Client Wishes: Legislative Change and Practice Opportunities

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July 2008

Levels of Intervention

Option 1: Supportive care such as nursing care, relief of pain, control of fever, fluids & continued management of standing chronic conditions. No C.P.R.

Option 2: Option one plus therapeutic measures & medications to manage acute conditions within the limits of the residential care facility & program to which they are admitted. No C.P.R.

Option 3: Option two plus admission to an acute care hospital (if not already admitted) for medical/surgical treatment as indicated. No referral to critical care. No C.P.R.

Option 4: Maximum therapeutic effort as in Option 3 above including referral to critical care & use of C.P.R. if indicated.

Policy Objective

- Providing a framework for conversation about patient's goals for care at end of life

Duty to Treat

“Once the physician-patient relationship exists, there is a duty to treat. The standard of treatment is no different for the terminally ill patient than for any other patient.”

William J. Sullivan, BA, LLB, MCL cf. “Autonomy and the Terminally Ill Patient” BCMJ. Vol. 43, No. 6 July/August 2001, pages 342-345

Autonomy Requires Communication

“The exercise of power by the physician can be cloaked in the guise of beneficence, but it is still the denial of patient autonomy. Approaches to treatment must be made with a knowledge of the patient’s values and how treatment will interact with those values. Consent to treatment is not just a legal requirement. Health information is necessary for the patient to make decisions and it is the ethical and legal obligation of the physician to communicate that information.”

William J. Sullivan BA,LLB, MCL **Guild, Yule & Company, Vancouver, B.C.**

“Autonomy and the Terminally Ill Patient” BCMJ, Vol. 43, No.6 p. 342-345

Cardiopulmonary Resuscitation (CPR)

DNR (do not resuscitate) orders:

No INTUBATION



No COMPRESSIONS



No DEFIBRILLATION



Applying Principles to End of Life Conversation about CPR

*Collaboratively determine treatment goal(s):

e.g. - survive the resuscitation attempt

- survive 24 hours
- survive to discharge, or
- other goal

Default Position: Provide CPR unless there has been a discussion with patient/resident to the contrary

Truog RD, Brett AS, Frader J “The problem with futility”
N. England J Med 1992;326:1560-1564.

Anticipated Problems: Disagreement

What if the health care provider and patient/resident disagree about whether or not CPR can help achieve the goal?

DO NOT RESORT TO UNILATERAL DECISION-MAKING

Possible Solutions

SHARED DECISION MAKING

or

CONFLICT RESOLUTION

Shared Decision Making

1. Current Medical Status

2. Interventions

- *Description

- *Risks and Benefits

- *Likely Course(s) with/out therapy

3. Professional Opinion

“The Story of Iphigenia” told by J.Katz in “*The Silent World of the Patient and the Doctor*” pp.90-93

Shared Decision-Making Is Successful in Practice

“When patients were provided with accurate information
23 of 24 patients rejected resuscitation.”

Donald Murphy, Medical Director,
Nursing Home

Comparable Clinical Circumstances

“Donald Murphy reported that when he became medical director of a nursing home only 10% of the multiple impaired, elderly patients had do not resuscitate orders. “

Younger S. “Applying Futility, Saying No Is Not Enough” Journal of the American Geriatrics Society, Volume 42 number 8 (1994), pp. 887-889

Communication Which was Goal Centered and Collaborative

“He changed the way the issue was approached.

He encouraged discussion about death and dying and avoided using misleading euphemisms like, “Would you want us to do everything possible to save your life if your heart stopped beating?”

Younger, Ibid

Fostering the Exercise of Autonomy Successfully.....

“When he provided patients and families with accurate descriptions of their medical conditions, poor prognoses, and the unpleasant realities of dying in critical care environments, they uniformly (23 of 24 patients and all but one relative of incompetent patients) rejected resuscitation. None refused to discuss these difficult issues because they felt uncomfortable.”

Younger, Ibid

Outcomes.....

“By taking this direct approach, Murphy truly empowered his patients and their families and avoided the ‘gun fight at the OK Corral’, where futile CPR is demanded and physicians must ‘draw’ their futility trump card.”

Younger, Ibid

Dispute Resolving Mechanism

1. Make every attempt to avoid an impasse by engaging in regular and sustained discussion
2. In circumstances of disagreement, attempt to clarify any factual misunderstandings (fundamental or non-fundamental disagreement)
3. Unresolved dispute: transfer and/or consult Ethics Services