Q&As

DNR Orders
and the Elderly
Delicate Discussions

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Nowhere else in medicine are doctors legislated to discuss the non-offering of a specific treatment. All consent discussions revolve around the concept that we want to perform a diagnostic test or offer a therapy, and the patient agrees or refuses. Sometimes, a patient or family will suggest a test or treatment; we all debate the value and risks and come to a conclusion. This is not the case in the "Do Not Resuscitate" (DNR) discussion.

Even though doctors believe that, in certain situations, cardiopulmonary resuscitation (CPR) will not work in the event of a cardiac stoppage, the law states we must discuss the issue with the patient, if competent, or with the next of kin.

We must bring up the subject of end-of-life situations, explain the pathophysiology of cardiac stoppage, outline the response rate to the procedure, and wrest some kind of agreement for a DNR order. This process is never easy; as death approaches, end-of-life anxiety increases for patient, family, and medical team.

Jack's dilemma

Jack, a long-time patient, comes to your office asking about his 80-year-old father, who was recently admitted to a nursing home because of:

- frailty,
- advanced dementia,
- stroke,
- peripheral vascular disease, and
- chronic renal failure secondary to diabetes.

At the home, the attending doctor asks Jack to think about a "Do Not Resuscitate" (DNR) order for his father.

What would you advise Jack to do about this?

What would you do if you were the attending physician for Jack's father?

For a followup, go to page 67.

Q What are the numbers to know?

A Acute cardiac arrest in an independent, community-dwelling, elderly person leads to sudden death. If this otherwise healthy person is defibrillated within five minutes, the discharge rate from hospital is between 5% and 12% and the resulting long-term quality of life is somewhat better than for a similar population of stroke survivors.

In chronically ill people, the dying process is the end result of metabolic, nutritional, psychosocial, and immunologic involution; CPR given to such people results in no discharges from hospital. Furthermore, for 10% to 25% of those who initially respond to CPR and make it to the hospital, death occurs in the intensive care unit, with the patients hooked to ventilators and vasopressors.

Few to none return to the nursing home to die among staff who know them and their families.

At this point, it is important to differentiate between cardiac arrest and heart stoppage:

- *Cardiac arrest* results from acute myocardial ischemia secondary to myocardial arterial occlusion.
- *Heart stoppage* is the result of prolonged terminal illness and is the end point of this illness, not the illness itself. CPR does not work in this situation.

Q What do the studies say?

A Three authors have reported on the outcome of CPR in nursing home patients who have suffered a cardiac arrest. Of 294 home residents, 14 survived and returned to the home. A subanalysis revealed all the survivors were either recently admitted to the home or were there for respite. No bed-bound, long-term residents survived.

Advising Jack

Talking to Jack about his father's lifelong approach to illness, medical treatments, and death might offer insights into his and his family's attitudes.

If his father is someone who wants every treatment going, you could discuss futility. If the father is more passive and philosophical, you might take the "He wouldn't have wanted it anyway" approach.

My in-office answer for Jack would be for him to tell his father's doctor to write DNR on the chart as soon as possible.

If I was Jack's father's attending physician, I would explain to Jack that CPR is not effective and that it will not be performed when his father's heart stops beating. If Jack wishes to, I would discuss DNR, but would NOT force Jack to make this decision.

Attempting to force a decision from Jack may make him feel as if he is contributing to his father's demise, and he may blame himself for years to come. He may have naively promised his father that everything would be done.

The treating doctor should take responsibility for medical decisions. If a treatment isn't going to work, it should not be offered.

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Q What should GPs do?

A Doctors need to provide some realistic education to patients entering nursing homes and to their families, as there is a large discrepancy between the actual effectiveness of CPR and the estimated effectiveness (see Frequently Asked Questions).

The law on DNR states physicians need a discussion about the issue, not consent. No doctor in Canada has been sued for writing a DNR order. Dx

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Frequently Asked Questions

1. How effective is CPR in elderly people living in nursing homes?
Studies show survival in nursing home populations vary from 0% to 5% for all residents, but is much lower for those who are bed-bound.

2. How effective is CPR in the *opinion* of an elderly person's family?
The families of community-dwelling elderly people believe CPR will work 45% of the time. The actual rate of hospital discharge in this population is < 10% and < 5% if the elderly person is chronically ill.

3. How many elderly people actually want CPR?
Sixty-four per cent of the elderly feel they should have CPR performed in the event of a cardiac arrest.

4. What percent of families want CPR for their elderly relative?
Seventy-five per cent of family members feel CPR should be performed on their elderly relative in the event of a cardiac arrest.