

TEACHABLE
MOMENT

LESS IS MORE

When Do Not Resuscitate Is a Nonchoice Choice
A Teachable Moment**Michael J. Nabozny, MD**Department of Surgery,
University of Wisconsin,
Madison.**Nicole M. Steffens, MPH**Department of Surgery,
University of Wisconsin,
Madison.**Margaret L. Schwarze, MD, MPP**Department of Surgery,
University of Wisconsin,
Madison; and
Department of Medical
History and Bioethics,
University of
Wisconsin, Madison.**Story From the Front Lines**

A 70-year-old man presented to our hospital for elective descending thoracic aortic aneurysm repair. Four years earlier, the patient had experienced acute aortic dissection of the descending aorta and was effectively treated with tight blood pressure control. This dissection was followed with serial imaging and his aorta slowly expanded to 6.5 cm. The patient reported intermittent back pain, fatigue, and weakness progressing over several months. After extensive discussion with the vascular surgeon and routine cardiopulmonary testing, the patient was brought to the operating room for replacement of his arch and thoracic aorta.

After 8 hours of surgery, the new aortic graft was in place when the patient suddenly developed acute coagulopathy necessitating massive transfusion and vasopressor support. Despite prolonged, aggressive efforts to reverse this nonsurgical bleeding, the surgeon was unable to halt the massive hemorrhage; the etiology of the coagulopathy was undetermined. He believed the patient's death to be imminent and informed the patient's family. The patient returned to the intensive care unit (ICU) on maximal hemodynamic support.

In the ICU, the treating physician spoke to the patient's wife. She described it this way to us, "[he] came out and talked to us. And, you know, he had to ask the question, would we want to do CPR?" She asked him whether cardiopulmonary resuscitation (CPR) would serve any purpose and he confirmed that it would not, given the uncontrollable bleeding; it would only prolong the dying process. Now, 3 months after her husband's death, she continues to worry that her decision to withhold resuscitation contributed to his death. She recounts, "And I've asked myself that question afterwards, you know. Should I let him go ahead and do the CPR? But, you know, according to their outlook on it, it wouldn't have changed anything. So I didn't want to put him through that... It's the hardest decision I've ever made."

Teachable Moment

Unfortunately, the patient experienced an outcome that neither the family nor the surgeon expected. The patient's death was foretold in the operating room when the surgeon determined that the coagulopathy could not be reversed. However, the patient's death actually occurred in the ICU, where institutional guidelines and cultural norms posit CPR as the default

option. To support patient autonomy, we reflexively ask all patients and/or their families to actively give permission to withhold CPR regardless of its expected effectiveness.

While this patient represents an extreme example of physiologic futility, there are many other patients who similarly would not benefit from attempted CPR including those with metastatic cancer, major trauma, or end-stage liver disease.¹ Yet CPR has been the default treatment for all patients since the 1970s² and patients or surrogates must generally consent to a do-not-resuscitate (DNR) order to restrain medical staff from performing CPR. Offering choices about ineffective treatment (essentially nonchoices) to patients and families at the end of life harms survivors because they feel accountable for this decision associated with conflict and regret.³ Family members are pressured to make an in-the-moment, life-and-death choice, creating the illusion that they bear some responsibility for a loved one's death.⁴

Many hospitals, including our own, have policies that allow physicians to withhold or withdraw treatment in the setting of physiologic futility. However, as we show here, defining futility is fraught with hazard and clinicians are so accustomed to asking patients and/or surrogates to endorse DNR that they fail to recognize situations when CPR is not an acceptable choice. For this patient and for others for whom CPR is inappropriate, a **better approach would be to inform surrogates that CPR will not be performed during the dying process and check for dissent.** For example, "**We will keep him as comfortable as possible and when his heart stops, we will not attempt to restart it. Does this make sense to you?**" This framework would (1) send a message that clinicians will **continue to care for** the patient, (2) clarify that the use of **CPR is not a treatment that requires deliberation or ownership by the surrogate,** and (3) confirm that family members **understand that CPR will not be used.**⁵ It can readily be adapted to a variety of clinical scenarios.

Honoring patients' autonomy by helping them to make informed medical decisions is deeply respectful of their right to self-determination. However, presenting CPR as an appropriate treatment option and asking patients or surrogates to choose between CPR and DNR for imminently and irreversibly dying patients **does nothing to enhance autonomy and can harm survivors.** A more nuanced approach would ease the burden of actively "choosing" to forgo attempts at CPR and still inform patients and families of the expected course.

Corresponding Author:
Michael J. Nabozny, MD,
Department of Surgery,
University of Wisconsin,
600 Highland Ave,
H4/785, Madison, WI
53792 (mnabozny
@uwhealth.org).

Published Online: June 15, 2015.
doi:10.1001/jamainternmed.2015.2326.

Conflict of Interest Disclosures: None reported.

Funding/Support: Dr Schwarze is supported by a training award (KL2TRO00428) from the Clinical and Translational Science Award program, through the National Institutes of Health National Center for Advancing Translational Sciences, grant (UL1TRO00427), and the Greenwall Foundation (Greenwall Faculty Scholars Program.)

Role of the Funder/Sponsor: These funding sources had no role in the design and conduct of the study; collection, management, analysis, and

interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

1. Larkin GL, Copes WS, Nathanson BH, Kaye W. Pre-resuscitation factors associated with mortality in 49,130 cases of in-hospital cardiac arrest: a report from the National Registry for Cardiopulmonary Resuscitation. *Resuscitation*. 2010;81(3):302-311.
2. Rabkin MT, Gillerman G, Rice NR. Orders not to resuscitate. *N Engl J Med*. 1976;295(7):364-366.
3. Kaufman SR. *And a Time to Die: How American Hospitals Shape the End of Life*. New York, NY: Scribner; 2005.

4. Schenker Y, Crowley-Matoka M, Dohan D, Tiver GA, Arnold RM, White DB. I don't want to be the one saying 'we should just let him die': intrapersonal tensions experienced by surrogate decision makers in the ICU. *J Gen Intern Med*. 2012;27(12):1657-1665.

5. Blinderman CD, Krakauer EL, Solomon MZ. Time to revise the approach to determining cardiopulmonary resuscitation status. *JAMA*. 2012;307(9):917-918.