



David A. Fleming, MD
315 Clark Hall
Columbia, MO 65211

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Partial DNR Orders

Writing formal “Do Not Resuscitate” (DNR) orders is a relatively new practice that has come about over the last 30 years as a result of medical innovation coupled with a growing understanding that sometimes it’s just not in the patient’s best interest to delay the process of dying, even if we can. The notion of doing a “partial code”, such as selectively not intubating or using medication only (“chemical code”), arose out of the recent patient autonomy movement and the innovation of encouraging detailed healthcare directives that allow patients and families to participate in treatment decisions and selectively choose which of many interventions they would or would not want in certain scenarios, should they be at high risk for death. The “slow code” is more sinister, and dictates the aesthetic appearance of, but not the full substance of, a full resuscitative effort by the healthcare team for the sake of family or others who might criticize (or worse, litigate). Many physicians are fearful that, “If we don’t give the appearance that “everything is being done” for the patient the family might sue.” This form of subterfuge by healthcare professionals, knowing (and planning) that the patient will die in the process, has thankfully fallen away in most institutions where systems of accountability and training discourage such unethical behavior.

But, there is still concern about the ethics of partial DNR orders.ⁱ Of all DNR orders fewer than 10% stipulate limited resuscitation,ⁱⁱ but when written they are often perplexing and difficult to follow, especially for the code team who is meeting the patient for the first time in extremis. Partial DNRs are also ethically problematic when the intent is to allow the patient or family to choose among certain interventions that they assume will be beneficial, while we know the probability that the patient will die anyway, in spite of these limited efforts. Depending on the severity of illness, chronically ill elderly patients have less than a 5% chance of surviving to discharge after a full resuscitative effort in the hospital.ⁱⁱⁱ The chance of surviving such an event approaches zero with limited resuscitation. When patients with chronic illness and a poor prognosis are fully informed about a poor prognosis they usually do not want CPR of any kind.^{iv}

Orders that limit treatment should be written with care and caution, and only when the patient and family have been educated about the limited scope of DNR and orders selectively limiting care. Care plans should be developed for the patient that incorporate the patient’s goals of care, and provide for specific refusal of treatment options that will allow for physician discretion in order to reach these goals when “code” situations occur. Goals of care may instruct us to pursue survival at all costs, palliation only, or to use only those means that will preserve cognitive or functional status. Different goals may call for the use of all or some selected interventions.

Berger argues that partial resuscitation should be avoided except when the patient or surrogate, together with the physician, can define a clear and medically reasonable objective that can be met with limited treatment, and that does not cause disproportionate suffering to the patient.¹ No intubation orders should also be written only when these conditions are met. Care should also be taken not to offer the selection of interventions that, exclusive of others, offer no realistic hope of survival, such as permitting CPR but not defibrillation—this just won't work when ventricular fibrillation suddenly hits. Patients and families rely on us to educate them as to the combinations that realistically will and will not be effective, and to offer those combinations of interventions that have a realistic chance of success in consideration of their stated goals of treatment. As always, clearly documenting any discussion about limiting treatment and the patient's goals of care in the medical record, and being clear and concise in writing the order, are of critical importance to the welfare of the patient.

ⁱ Berger J. Ethical Challenges of Partial Do-Not-Resuscitate (DNR) Orders. *Arch Int Med* 2003; 163:2270-2275

ⁱⁱ Dumont J. et al. Outcome of Adult Cardiopulmonary Resuscitation at a Tertiary Referral Center, Including Results of "Limited" Resuscitation." *Arch Int Med*. 2001; 161:1751-1758

ⁱⁱⁱ Murphy D, et al. Outcomes of Cardiopulmonary Resuscitation in the Elderly. *Ann Int Med* 1989; 111:199-205

^{iv} Murphy D, et al. The Influence of the Probability of Survival on Patients' Preferences Regarding Cardiopulmonary Resuscitation. *NEJM* 1994; 330:545-549