Dear fellow Medical Directors,

“Do Not Resuscitate” (DNR) is a term used to indicate when a person is found to be in the active dying process that we will provide comfort measures and let them pass naturally, as opposed to performing CPR (cardiopulmonary resuscitation). There are many facts and myths regarding CPR and DNR orders that need to be clarified in order to help make the best decision for responsible parties and their loved ones. DNR status should be taken very seriously and with appropriate thought to the risks, benefits and the appropriateness to the person involved.

**MYTH: DNR equals “Do Not Care”**

Nothing could be further from the truth. DNR is simply not doing a medical procedure that was originally designed for younger patients in their 50s and 60s having an acute myocardial infarction. A DNR order in a nursing home means absolutely everything will be done up to the point that the patient is found to be in the active dying process. Labs and tests will be done. Antibiotics will be ordered. Patients will go the hospital. 911 can be called, and any and all other measures can be entertained. If the person or patient wants more specific orders to indicate they want “comfort measures only,” such as “Do Not Hospitalize,” “Do Not Give IV Antibiotics,” etc., these must be individually specified and have absolutely nothing to do with a DNR order. DNR pertains ONLY to the active dying process and not to any other stage.

**MYTH: CPR is usually successful**

CPR is usually unsuccessful in nursing home patients. A well-recognized medical journal noted that on TV shows, CPR is successful half the time. Nothing could be further from the truth. In younger people, CPR is successful 15-25% of the time under ideal circumstances. In older patients residing in nursing homes, studies have shown there is only a 3 percent overall success rate. Many of these people are much more impaired after they return from the hospital. CPR is considered by many medical authorities to be essentially futile in nursing home residents. It is, however, a personal decision and the right of the individual to request it.

**MYTH: CPR can’t hurt**

CPR is an aggressive medical measure in which the chest is compressed upon vigorously. Frail older patients usually have multiple rib fractures from this procedure. This normally results in people being left on ventilators for long periods of time due to inability to breathe on their own, during which time they often develop pneumonias and have other complications. This is one of many reasons why CPR is not usually successful in older patients. The patients are often semi-awake during the procedure and may be very aware of chest compressions and ribs being broken, and may experience severe pain afterwards. Being on a ventilator is not a pleasant experience, especially for people with cognitive impairment who can be extremely confused and in frightful distress during their time in the hospital Intensive Care Unit. Doctors take the Hippocratic Oath to “do no harm.”
seriously. CPR on the wrong person unfortunately usually causes far more harm than any potential good.

**MYTH: “Doing everything” means we need to do CPR**

Again nothing could be further from the truth. “Doing everything,” means doing everything that is right medically and ethically for that patient at that time. At different times in a patient’s life, different medical interventions are appropriate. It would be rare to find a 50-year-old person who should not undergo heart surgery. However, it would be rare to find a 90-year-old demented person that would be appropriate for major surgery. Similarly, doing CPR on a very old person with osteoporosis, heart disease, strokes or other serious diseases, is often very medically inappropriate. It is more akin to doing the wrong thing than doing “everything.” While a difficult decisions, more often “doing everything” means keeping the person comfortable, maximizing their everyday quality of life, and providing for their daily emotional and physical comfort. Inappropriate aggressive measures can make their last days on this earth painful and mentally agonizing, and do not allow them to have the peaceful death that most persons want.

**FACT: We must do what the patient wants**

As a medical doctor, I often find that families are torn about what to do when it comes to a DNR order. I will usually ask the family, “If your loved one had been able to look into a crystal ball 30 years ago and could have seen his or her current life and condition, what would he or she have wanted done?” More often than not, when this perspective is taken, families will realize that their loved one would not have wanted to undergo aggressive measures at this stage in their life. Instead they often realize their loved one would have wanted to be allowed to have a natural death rather than to undergo aggressive medical procedures with limited ability to help and far greater potential to harm. Many older people did not express exact wishes. Sometimes they may have known a relative who underwent medical procedures and went through a painful death, and may have noted that they would not want that to happen to them. This is tantamount to expressing their personal wishes.

The adult children acting as a responsible party for their incapacitated parent can have an especially difficult time making a DNR order. They may feel they are abandoning their parent or not providing him or her with every opportunity of life. As responsible parties, they have a moral obligation to do both what their parents would have wanted and what is in their best medical interests. Remember, responsible parties are to express the patients’ wishes and not their own desires. Responsible parties should speak to the physician and have a meaningful discussion regarding their loved one’s prognoses and the ability of CPR to be successful. In this way, both an intelligent and a correct ethical decision regarding a DNR can be made. DNR is about doing the right thing medically and morally. It is not about giving up, but giving the best care.

Sincerely,

Charles A. Crecelius, MD, PhD, CMD
Medical Director
Missouri Quality Initiative (MOQI) for Nursing Homes