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The Ethics of a DNR

Many people struggle with the ethical discernment surrounding the decision to have a Do Not Resuscitate Order (DNR) put into place for themselves or a loved one. The DNR is a specific medical order. "It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating." There are circumstances where faithful Catholic bioethicists agree that a DNR can be moral and others where it is not.

The dilemma has become more severe in recent years because biomedical science has achieved a very high level of efficiency when it comes to resuscitation. This is one of those areas where the gap between what one "can" do and what one "should" do has widened considerably. There is no doubt that the mind of the Church is pro-life and that we have an ethical duty to reject suicide or euthanasia. We should seek to prevent death, as stated in The Ethical and Religious Directives for Catholic Health Care Services (ERDS) # 56. "A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community."

This directive points to the fact that the Church rejects the view that we are morally required to employ every means available to save the life of a patient no matter what the burden or cost. Pope Saint John Paul II said this clearly in his famous Encyclical Letter *Evangelium Vitae* in section # 65.

> Certainly, there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the

> means of treatment available are objectively proportionate to the prospects for improvement. To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death.

In short, a DNR medical order could be ethically acceptable, but careful discernment is necessary.

I would hasten to add a few *caveats*, however, that are extremely important. First, the ordinary position is that persons should receive medical resuscitation if they collapse or go into cardiac arrest. The presumption is that attempting to save a person's life is the right decision in most cases. Second, resuscitation is ordinary care unless prudent discernment has determined that it is not the best ethical choice in a specific case.

There is a worrying trend to put DNRs in place quickly and without seeking sufficient informed consent from individuals or their medical proxies if they are incapable of giving consent. Some institutions and medical professionals seek to obtain DNRs for a variety of non-ethical reasons. One of the most basic ones is economic cost reduction. It is undoubtedly cheaper to allow a patient to die rather than to resuscitate him or her and have them go on living in a hospital bed. I believe this is increasingly a driving force in some medical decision-making. Also, a consequence of the very prominent culture of death in our world is the view that many persons have "lives not worth living" who should have their deaths hastened in a variety of ways. Our current cultural context points to the need to exercise a great deal of caution before making a DNR decision.

At The National Catholic Bioethics Center (NCBC) we frequently receive personal ethical consultation requests that involve difficult end of life care choices, including the appropriateness of a DNR. Sometimes individuals are told by health care workers that if their loved ones do not have a DNR they will be subjected to aggressive CPR with the high

likelihood of breaking their ribs or very painful electroshocks from the "paddles" used to jolt the heart back into beating. Hollywood dramas love to present these kinds of intense patient resuscitation scenes that elicit a strong visceral reaction. It is hard not to see an attempt at emotional blackmail in some of these graphic descriptions that are given to patients or their medical decision-makers to push them into agreeing to a DNR.

Yes, the thought of bruised or broken ribs is unpleasant, but we should be willing to accept much greater sacrifices than those to save a life. What is most relevant is the objective situation of the patient, and if he or she is at the point where the burdens of resuscitation clearly outweigh the benefit of extending life. There is a clear difference, for example, between a vigorous young person who could easily recover from the resuscitation process and someone who is very elderly and fragile. One must never lose sight of the objective duty we have to preserve life, while balancing this moral obligation with the understanding that allowing a person to die is not the same thing as killing them if the burdens of keeping them alive become excessive.

Experienced Catholic ethicists, like those of the NCBC, can be of valuable assistance when the question of a DNR is posed. Emotions usually run high in these situations, and many are grateful to have a third party who knows Catholic moral principles well, providing insights and counsel for their specific case. Our free personal consultations service can be accessed through our website. Certainly, a DNR decision is momentous and should not be made lightly or in haste. The default position is to resuscitate and only in certain cases can the decision not to use CPR or other means of resuscitation be ethically justified.