Do-Not-Hospitalize Orders: Whose Goals? What Purpose?

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The touch of a good clinician is deft and sure. In diagnosis, skilled palpation neither misses deep masses through hesitancy nor causes pain and withdrawal through excessive vigor. In treatment, careful judgments take into account the narrow margin of error between potency and toxicity.

The same is true about decisions to withhold treatment. Physicians must neither impose unwanted therapies nor leave their patients without needed care. In their article[1] in this issue of the Journal, "The Use of Do-Not-Hospitalize Orders by Family Physicians in Ohio," Martin Lipsky and his colleagues thus identify an important problem: the tendency of nursing homes to send patients to hospitals without anyone ever questioning whether the treatments given there are expected to be of benefit or, indeed, without thinking about whether the patient at all desires the transfer. Just as resuscitation attempts can intrude on an otherwise peaceful dying process,[2] hospitalization as a reflex response to illness or injury clearly risks "loss of autonomy with undesired, expensive, and extensive stays in acute care facilities."[1]

Is a do-not-hospitalize (DNH) order (an analogy to do not resuscitate [DNR]) therefore the appropriate remedy? Perhaps in selected cases. But great caution is needed here. A DNH order issues a sweeping injunction against a wide range of possible future medical interventions. Rejecting this site of treatment can easily be read as rejecting treatment altogether. Such an order is problematic because making responsible decisions about what interventions to use or to forgo generally requires first specifying the relation of the proposed treatment to the patient's overall goal of management.

Identifying the goal of management is a critical initial step in good clinical and ethical decision making, especially when limitations on treatment are being considered. When cure or reversal of an underlying process is unavailable, treatment goals for such conditions as cancer or aging shift appropriately to maintaining biologic function (ie, prolonging life) or maximizing comfort. Because interventions designed to further survival frequently interfere with or undermine privacy and comfort, and because patients differ widely in their beliefs as to which goal should take priority and to what extent, clinicians must work with their patients to identify medically attainable and ethically sensitive goals of management.[3]

Lipsky et al observe that maximizing comfort is the primary management goal set for many nursing home patients. When this goal has been made explicit, and the patient or a legitimate surrogate has agreed to its priority, providing comfort care in the extended care facility offers many advantages. The staff knows the patient and can anticipate individual comfort needs, the environment is familiar and nonthreatening, and the daily routines are more congenial to comfort care than are those of the average hospital floor or intensive care unit.

Nonetheless, without reference to an immediate clinical context, it can be virtually impossible to know whether hospitalization will advance the management objectives identified in the patient's global care plan. Acute care hospitals can serve important objectives of comfort management, for example. Consider an 86-year-old mildly demented woman who has previously accepted a primary treatment goal of maximizing comfort. If she suffers a serious fall, should prior consent to a DNH order make her ineligible to go to the hospital and have her hip pinned? Some patients may be prepared to be treated under any circumstances in the nursing home rather than be moved to a hospital, but most will prefer to maintain an option to be transferred if it will in fact do them some good.

Nursing homes also serve many patients whose primary management goal is extending survival. Hospitalization obviously plays a central role in advancing the aims of these patients. Hence, care is needed so that the cost-saving features of some patients' freely chosen limits on

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treatment do not lead to coercive limits on the choices of others. (Societal choices about allocation should not be made covertly at the bedside but instead in public forums, with substantial opportunities for debate and review.) Educating patients and families about the difference between treating an underlying condition (such as progressive neurological decline) and treating secondary manifestations (such as aspiration pneumonia, waning appetite, and decubitus ulcers) should thus serve to animate rather than foreclose discussion about which secondary conditions should be treated and by what means.

As a part of any educational effort, individual hopes, fears, and values must be carefully explored. Through this effort, the patient or family is positioned to act responsibly in evaluating the kinds of burdens that will likely attend the pursuit of prolonged survival. Such notions as "medical futility," however, should be used to open rather than to close conversations, except in those relatively rare circumstances in which a given treatment cannot be expected even temporarily to prolong survival.

Consideration of the possible use of DNH orders in long-term care facilities thus provides an excellent framework for involving nursing home patients and their families in serious discussions about future treatment, including whether treatment should necessarily include hospitalization. But physicians and others who consider using DNH orders should be aware of a subtle danger: the tendency of such orders to obscure the complicated ethical judgments that frequently inform and shape a patient's treatment plans.

The problem is not simply that multiplying acronyms increases the risk of an error being committed ("Oh, that was DNH? I thought it said DNR!"). More fundamentally, the question is whether simplified acronymic orders, such as DNH, can capture the essence of good clinical and ethical judgments.

Medicine has always had its po's, qid's, and prn's. Perhaps a certain logic even justifies linking CPR with DNR. But the tendency of DNR to breed other acronyms for limiting treatment (eg, DNI for do not intubate) underscores the need for good clinicians, in collaboration with their patients, to develop and articulate management plans that are more than a string of shalls and shall nots. A unified and coherent comprehensive treatment plan can provide invaluable guidance to nursing home staff faced with a decision about treatment or transfer.

If an acronym is essential, perhaps it would be better to devise a strategy that required physician consultation before transfer. This could be deemed an HQ (hospital query) order, and it would generate questions such as the most important raised by Lipsky et al: Does the patient or family really understand the situation and the implications of continuing to strive for biologic survival? Could comfort therapies be supplied in the extended care facility? Will hospitalization truly serve the patient's management goals?

References

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