(cont) secondary to sleep or pain medication or, perhaps, recurrence of her CHF due to a failure to restrict her salt intake? With the DNR order in place, expectations regarding her prognosis and recovery may be lowered and the response to her symptoms may be less aggressive than might be considered the standard of care in non-DNR patients. In such cases, despite expectations by the patient, her family and her PCP, medical decision making may be clouded and the DNR status might actually contribute to her death.

Perhaps even more pernicious are situations in which a patient's chronic conditions (such as CAD and CRF), though well controlled prior to the hospitalization, are exacerbated by acute medical problems or by iatrogenic factors (e.g. volume overload). Hesitant to initiate aggressive therapy in an elderly patient with serious chronic medical conditions, the attending physician suggests a DNR status and, if agreed to, uses that consent to become lax about routine management and to forego interventions such as dialysis. If, on the other hand, the patient's acute problems are treated aggressively, he might recover completely and return to his previous level of functioning.

These common but unrecognized practices have tremendous implications for patients and their families. Whether intentional or not, clinicians may be making judgments that are based on cursory information and are often not in the best interest of the patient. While the reasons for such actions are not clearly defined, it is likely compounded by the increasing role of specialists and hospitalists in the care of inpatients, when they are most vulnerable and when input from their PCP and family may not be immediately available.

It is important that hospitalists recognize the full implications of actions that they take and decisions that they make on behalf of the patients that they serve. As patient advocates, we must make every effort to understand the true wishes of the patient and their family and take the time to discuss their baseline functional status with their primary physician prior to initiating any care restrictions. Patients and their families must also be educated regarding the potential implications of a DNR order and should be encouraged to share their views regarding any limitation of care. Above all else, we must come to appreciate our own innate biases and resolve to distinguish DNR from Do Not Treat.

HOSPITALIST CONFERENCE & LUNCHEON

MISSOURI ACP MEETING

SATURDAY, SEPTEMBER 26, 12:15 PM

TAN-TAR-A RESORT, LAKE OF THE OZARKS

TOPIC: HOSPITAL ACQUIRED INFECTIONS

http://www.acponline.org/meetings/chapter/mo-2009.pdf