VIEWPOINT

The Importance of Addressing Advance Care Planning and Decisions About Do-Not-Resuscitate Orders During Novel Coronavirus 2019 (COVID-19)

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The novel coronavirus disease 2019 (COVID-19) pandemic is challenging health care systems worldwide and raising important ethical issues, especially regarding the potential need for rationing health care in the context of scarce resources and crisis capacity. Even if capacity to provide care is sufficient, one priority should be addressing goals of care in the setting of acute life-threatening illness, especially for patients with chronic, life-limiting disease.

Clinicians should ensure patients receive the care they want, aligning the care that is delivered with patients' values and goals. The importance of goal-concordant care is not new or even substantially different in the context of this pandemic, but the importance of providing goal-concordant care is now heightened in several ways. Patients most likely to develop severe illness will be older and have greater burden of chronic illness—exactly those who may wish to forgo prolonged life support and who may find their quality of life unacceptable after prolonged life support.[1] In addition, recent reports suggest that survival may be substantially lower when acute respiratory distress syndrome is associated with COVID-19 vs when it is associated with other etiologies.[2,3]

In this context, advance care planning prior to serious acute illness and discussions about goals of care at the onset of serious acute illness should be a high priority for 3 reasons. First, clinicians should always strive to avoid intensive life-sustaining treatments when unwanted by patients. Second, avoiding nonbeneficial or unwanted high-intensity care becomes especially important in times of stress on health care capacity. Third, provision of nonbeneficial or unwanted high-intensity care may put other patients, family members, and health care workers at higher risk of transmission of severe acute respiratory syndrome coronavirus 2. Now is the time to implement advance care planning to ensure patients do not receive care they would not want if they become too severely ill to make their own decisions. As eloquently pointed out by an intensivist, "If you do not talk with [your family] about this now, you may have to have a much more difficult conversation with me later."[4] Several online resources can guide these advance care planning discussions.[5-7]

For patients in a community setting or living in a nursing home, clinicians should engage in discussions about goals of care now, especially with older patients with chronic disease. During this pandemic when nonessential medical visits are currently limited, these conversations may need to occur via telemedicine (either as a stand-alone appointment or in combination with an appointment designated or scheduled for another purpose). This process should include primary care and specialty clinicians (eg, cardiologists, pulmonologists, nephrologists, oncologists, and geriatricians), and patients might appreciate this opportunity to discuss advance care planning. Depending on state regulations, patients with chronic life-limiting illness should be offered the option to complete a physician order for life-sustaining treatments form, especially if they would not want to receive cardiopulmonary resuscitation (CPR) or mechanical ventilation.

For hospitalized patients, one focal point for goal-concordant care is related to discussions of code status or the use of CPR and advanced cardiac life support (ACLS). Many hospital-based clinicians overemphasize code status as the first step of a goals-of-care discussion, but asking patients about CPR before assessing values and goals leads to ineffective code status discussions. During this pandemic, it is equally important to understand a patient's values and goals prior to discussing code status; however, the importance of avoiding inappropriate CPR has increased for 2 reasons. One reason is that although unwanted or nonbeneficial CPR under any circumstance may risk increasing psychological distress for patients' family members,[8] inappropriate CPR during the pandemic is especially stressful and potentially dangerous for health care workers. Another reason is that nonbeneficial or unwanted ACLS will strain available resources for personal protective equipment because multiple health care workers are needed for effective ACLS. Therefore, the COVID-19 pandemic heightens the importance of implementing do-not-resuscitate (DNR) orders for appropriate hospitalized patients.

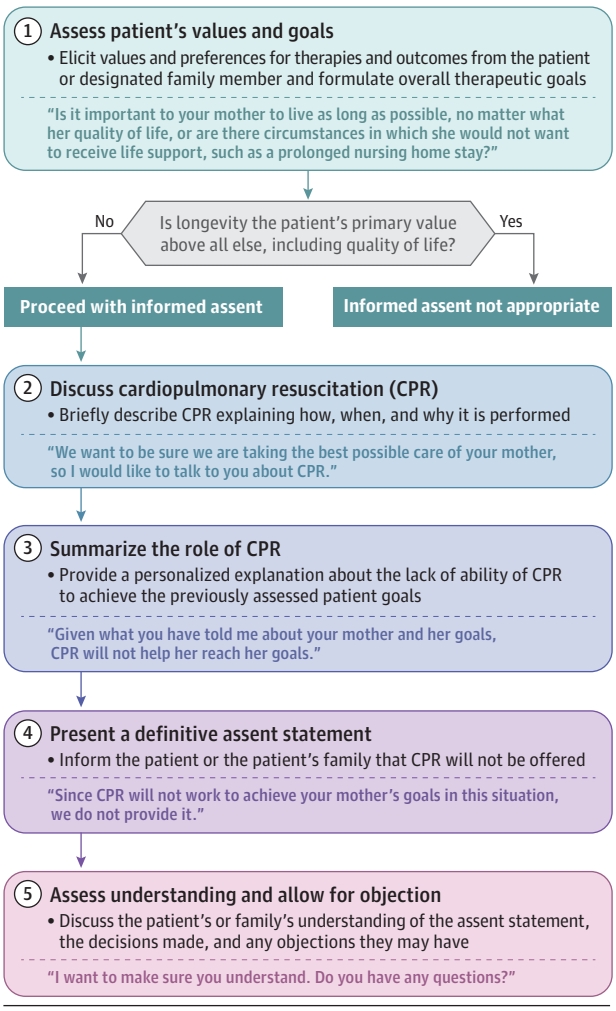
The implementation of DNR orders can occur in 3 situations. First, patients or their surrogate decision makers may clearly understand and communicate that the patient would not want CPR if the heart were to stop and may even have a physician's order for life-sustaining treatments form that specifies such. Second, patients or their surrogate decision makers may follow the recommendation of a clinician to forgo CPR; this may occur through informed consent or, occasionally, informed assent (as discussed below).[9] Third, in extreme situations in which CPR cannot possibly be effective, clinicians in some health care settings may unilaterally decide to write a DNR order.[10] This latter approach is not uniformly accepted and, prior to COVID-19, it rarely had a role. During this pandemic, however, in extreme situations such as a patient with severe underlying chronic illness and

acute cardiopulmonary failure who is getting worse despite maximal therapy, there may be a role for a unilateral DNR to reduce the risk of medically futile CPR to patients, families, and health care workers.[10]

Informed assent may be a more acceptable approach to code status discussions than medical futility and may be useful for patients in whom CPR is exceedingly unlikely to allow a successful return to a quality of life they would find acceptable.[9] The **Figure** provides a proposed guide for an approach to having an informed assent discussion with a patient or family member of a patient for whom the clinician believes CPR is not indicated. The advantage of informed assent over a more traditional informed consent approach is that the clinician does not ask the patient or designated family member to take responsibility for the decision but rather asks the patient or family member to allow the clinician to assume responsibility. Some family members may be willing to permit clinicians to make this decision while simultaneously being unable to accept responsibility themselves, even if they agree, because of the psychological burden it places on them. In this setting, informed assent may provide family members a way to agree with the clinician's determination without assuming responsibility. Importantly, this approach places great responsibility on clinicians to enact careful prognostication and thoughtful, respectful, open communication with family members. This same responsibility is also present for informed consent.

The COVID-19 pandemic is placing tremendous stress on health care systems. There are many important components of an appropriate response to this pandemic, including public health measures to reduce rapidity and extent of spread. Another important element of the best possible response is to ensure that clinicians have high-quality discussions both about advance care planning for individuals in the community, especially those of older age and with chronic illness, and about goals of care with patients or their families when patients have illness that requires hospitalization.

Figure. Proposed Components of Informed Assent Framework



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