Inez Madera, RN Pascal J. de Caprariis, MD Alex Carballo-Dieguez, PhD
Gladys Rodriguez, CSW Michael Stehney, MD Steven F. Dansky, CSW Ernest Visconti, MD

Approaching the "Do Not Resuscitate" Issue with AIDS Patients

Ms. Madera is Nurse Clinician in the Special Care Immunology Service of the Lutheran Medical Center in Brooklyn, NY. Dr. de Caprariis is Medical Supervisor of the Special Care Immunology Service. Dr. Carballo-Dieguez and Ms. Rodriguez are members of staff in the Special Care Immunology Service. Dr. Stehney is Director of Ambulatory Care at the Sunset Park Family Health Center. Mr. Dansky is a member of the Department of Social Services and Dr. Visconti is Chief of Infectious Disease at the Lutheran Medical Center. Requests for reprints to: Dr. Pascal J. de Caprariis, Sunset Park Family Health Center, Lutheran Medical Center, 150–55th St., Brooklyn, NY, U.S.A. 11220.

WHEN TERMINALLY ILL patients are admitted to the hospital, the decision to resuscitate often rests with the patient or family. The time of hospital admission may not be an ideal setting to address the "do not resuscitate" (DNR) issue. Many states in the U.S. have pending or no legislation concerning the DNR question. When the issue is resolved legally, however, the problem of when and where it should be approached will still remain.

We have assessed the charts of all AIDS patients admitted to our hospital from March 1983 through July 19, 1988. Only two charts of 76 were unavailable for review. The 74 charts reviewed showed that 50% of patients died in the hospital, 39% were discharged, 3% signed out against medical advice, and 8% remain hospitalized. Of the 37 patients that died at the Lutheran Medical Center, only 30% had DNR orders; 70% were resuscitated.

It is interesting to note that there was no written documentation of any discussion, with the patient or family, about options other than the use of aggressive life-support systems in any of the cases that were resuscitated. In cases with DNR orders, the decision had been made by the patient or family during the hospitalization period. Only one patient came to the hospital with a living will. It is surprising that the DNR issue had never been raised before the crisis of an admission.

Intravenous drug abusers make up 63% of our AIDS patients. They often lack family support, legal counsel, and financial resources. Intravenous drug abusers usually do not have a primary physician, and often will have various physicians assigned to them on admission, thereby contributing to a fragmentation of information.

Drug abusers are frequently unaware of the resources that are offered to AIDS patients and rely on the hospital social service department for obtaining these resources. Therefore, it is incumbent upon social workers whose patients have AIDS to be aware of the biopsychosocial implications of HIV infection and of the government and community resources available. Many intravenous drug abusers with AIDS are unaware that they can request DNR orders.

We believe that our experience at the Lutheran Medical Center can assist other institutions with the dilemma encountered with terminally ill AIDS patients.[1] The AIDS patient and family must be asked about possible limitation of aggressive medical management. It would be best to discuss this with AIDS patients while they are still ambulatory. Patients' psychological status would have to be evaluated in order to approach the issue with sensitivity.[2]

Early discussion of DNR is beneficial for both the patients[3,4] and the case management team. The patients are generally healthier, are stronger, and have clearer minds than when they are hospitalized, and therefore are better able to make informed decisions. Contrary to popular beliefs, discussion of DNR may help decrease, rather than increase, anxiety. When patients are skillfully helped to explore their options, they end up feeling more in control of their fate. This helps prepare the patients for the process of dying.[5]

It is essential to use the services of mental health professionals trained in working with terminally ill patients to evaluate mental status, suicidal risk, and social support systems. Professionals in medicine, nursing, social work, and mental health act as a case management team. The team management benefits from this multi-disciplinary approach by sharing responsibility, by allowing discussion of patient management, and by reduction of professional burnout.

We believe that the DNR decision can be approached with dignity and should not be made under duress in a crisis situation.[6] Terminally ill AIDS patients are best approached in an ambulatory setting where they have an increased feeling of security and control over their decisions. ■

References

1. de Caprariis PJ, Stehney M, Carballo-Dieguez A, Madera I, Rodriguez G, Stiles J. Establishing a community hospital outpatient clinical service for AIDS patients and their families [Abstract]. *Can Fam Physician* 1988; 34:2121.

2. Bunn M, Blanchfield J, O'Brian A. Nursing the AIDS patient at home. *AIDS J Patient Care* 1987; (June):21–4.

3. Fahrner M, Clement M, Kline AL, et al. Helping young people face death: resuscitation status and outcome in first episode *Pneumocystis carinii* pneumonia (P.C.P.) [Abstract]. *Third International Conference on AIDS*, Washington DC: U.S. Department of Health and Human Services, June 1987, 154.

4. Bennett JA. Nurses talk about the challenge of AIDS. *Am J Nurs* 1987; (Sep):1151–6.

5. Steben M. AIDS clinical spectrum. In: *Proceedings of the 30th Annual Scientific Assembly*. Willowdale, Ont.: College of Family Physicians of Canada, 1988: W87–99.

6. Madera I, de Caprariis P, Carballo-Dieguez A, et al. How to discuss DNR with an AIDS patient. *South Med J* 1988; 81(9):51–5136.