

November 1977

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Sylvia C. Gendrop

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Recommended Citation

Gendrop, Sylvia C. (1977) "The Order: No Code," *The Linacre Quarterly*: Vol. 44: No. 4, Article 6.
Available at: <http://epublications.marquette.edu/lmq/vol44/iss4/6>

The Order: *No Code*

Sylvia C. Gendrop, R.N., M.S.

Mrs. Gendrop has served as a co-editor of this issue of Linacre; she has served as staff nurse at hospitals in New Hampshire and Massachusetts and since 1973 has been chairman of medical-surgical nursing at the Newton-Wellesley Hospital School of Nursing.

Concept of Man

Nursing theoretically embraces the concept of man evolving on a hierarchy of needs. Physical comfort and safety are no longer perceived as his highest achievements nor does their attainment necessarily define a state of completeness. If we are to trust our observations, our own felt aspirations, and advancement in psychological thought, we accept man's search for meaning, for aspiring to become self-realized. Maslow tells us man's highest level of being may be self-actualization. Erikson states that adult freedom and dignity involve integrity as opposed to despair.

Man accepts death at birth. Throughout life he reasonably and responsibly copes with crisis. The right to know his life span and choose his path remains his and his alone — no one presumes to decide for him. It would appear that, if man strives through self-determination to become more human and to live a full life, he unjustly loses all that he has gained if, in the end, he is stripped of his power and control by technological decision makers. Robert Veatch in *Death, Dying, and the Biological Revolution*, stresses that "Death offers man his last chance to express his human potential, to determine his own destiny."¹ Man's ultimate right, then, is to retain the power to know that death is near, to choose where he dies, the kind of care he receives, the persons with whom he wishes to be.

The codes of both nursing and medicine are based on the rights of the patient. The ethical and moral basis of the *No Code* issue does not revolve around the prognostic determinations of one person or around a patient classification committee (of which the nurse may be a member). Instead, *No Code* involves the right and obligation of the competent patient or appointed agent (family or friend) to determine and control his life-death.

Veatch lists certain moral principles regarding death and the rights of patients:

1. "The patients' control of decisions affecting their death and dying;
2. Preservation of the patient's freedom and dignity in the last of it;

3. Rejection of the assumption that moral policy expertise is the exclusive prerogative of technical experts;
4. Substitution of the patient's agent, normally the next of kin, when the individual is unable to act, and
5. Modification of public policy to allow individual autonomy and dignity to the greatest extent tolerable to the moral sense of society."²

The role of the patient is also upheld by Rabkin.

Notwithstanding the hospital's pro-life policy, the right of the patient to decline available medical procedures must be respected. For example, if a competent patient who is not irreversibly and irreparably ill issues instructions that under stated circumstances, he is opposed to certain procedures, the following guidelines should be observed. The physician should explore thoroughly with the patient the types of circumstances that might arise and warn that the consequences of a generalized prohibition may be to allow an unintended termination of life. If after a careful disclosure the patient persists . . . the physician is legally required to respect such instructions.³

The *No Code* Issue

The interdependent relationship of nursing and medicine requires a conjoint effort to formulate and deliver a plan of care based on the expressed and assessed needs of the patient. The nurse should be consulted as a colleague who is accountable and responsible for the minute-to-minute assessment, diagnosis and intervention; and is committed to the continuing comfort and care of this patient. The Clinical Care Committee of the Massachusetts General Hospital discusses this cooperative spirit.

If unit nurses and physicians do not understand the reasons for a specific treatment of a patient or fail to see how a specific treatment may reverse the course of a patient's illness, they are encouraged to request clarification.⁴

For some patients, care and comfort will ultimately include the *No Code* issue.

In *No Code* deliberations the role of the nurse relates to:

1. The nurse may provide some missing insight or some perception regarding the patient's response to treatment or expressed views of the patient and/or family.
2. Exclusion from the deliberatory aspect of this patient's care conveys a viewpoint that undermines the nurse's concept of accountability and is clearly not to the patient's best interest.
3. Supportive behavior on the part of the nurse to the physician and the physician to the nurse in this crisis situation helps each to cope with the overwhelming burden of caring for the hopelessly ill person. This important point is reinforced by the Massachusetts General Hospital Group. "When a responsible physician designates a patient for treatment in C (selective limitation of therapeutic measures) it is essential that he receive the support of the unit director, physician, nursing staff and own consultants."⁵
4. Nursing experience in minute-to-minute caring for the *No*

Code candidate poses many questions. Are we prolonging life or are we prolonging death? Is it morally right to prolong suffering and dying? Do we accept dying as a purely biological event; or do we recognize the interdependent *process* of dying — social, emotional, cultural, physical?

5. Each of us must examine our own concept of life and concept of death, and share with each other insights related to current health care practices. In an article entitled "Moral Development in Nursing Education," Ruth Bindler relates to this need: "I believe that the higher stages of moral reasoning will enable nurses to question rules and their own comfort in order to bring about changes in health care which will benefit greater numbers of persons and society as a whole."⁶ We must pose to ourselves the question: Are we raging against death because we ourselves are afraid? And most important, are we allowing technology to control humanity?
6. Although the task of inscribing the *written order No Code* is the legal responsibility of the attending physician, nursing recognizes and empathizes with those who must assume this heavy burden.
7. A verbal order and/or word of mouth *No Code* places the nurse in a moral dilemma that is an unfair burden. Without a written *No Code* order, the nurse may morally believe *No Code* to be the patient's expressed wish and in his best interest, but legally she is responsible for coding the patient.
Note: "A nurse should undertake resuscitative measures unless there is a *No Code* order on the chart prior to the event, and adequate "informed consent" has been obtained and recorded on the chart by the physician from the appropriate persons previous to the episode."⁷

Caring for the *No Code* Patient

"Caring" for the *No Code* patient is clearly the most obvious and direct moral and ethical responsibility on the part of the nurse. "Nothing . . . should indicate to medicine and nursing staff or the patient and family any intention to diminish the appropriate medical and nursing attention to be received by the patient."⁸ The *No Code* patient requires special nursing effort to ensure as much physical and psychological well-being as possible. Physically, the simple tasks of daily living often become painful, burdensome. The sensitive and perceptive nurse seeks to assist the patient to maintain dignity and comfort in activities for as long as feasible. She recognizes, accepts and deals with loss of abilities by providing changes with the patient in her care, at the appropriate time. For example, recently Mr. L., a terminal patient, was experiencing difficulty eating. He could no longer swallow large portions of food and was very slow in finishing his tray. Despite repeated reassurances that the nurse was able to devote this

time to assist him, he consistently refused to eat because it "took too long and I get too tired." Bok comments on this phenomenon, "More than fear of death itself it is the fear of lingering before death and of creating heavy burdens."⁹ Kelly looks at the patient role and the environmental stressors that affect the patient's ability to cope. "Until recently, the individual has felt helpless in his role as patient — and small wonder. Stripped of his individuality as well as his belongings, he is thrust into an alien environment where he has little control over what happens to him. He is surrounded by unidentified faces and unidentifiable equipment. His privacy is invaded, his dignity lost. He hesitates to complain or criticize because of fear of reprisals from the staff. He is reluctant to press for answers to his questions because a "busy" message is communicated loud and clear. Underlying all of this is his fear for his health or even his life."¹⁰ Cognizant of the multiple stressors preventing Mr. L. from eating, the nurse intervened by ordering a soft, small portion diet, planning his short out-of-bed periods between meals so that he could devote his energy at mealtime to eating, planning with Mrs. L. to arrange her visits around meal time so she could meaningfully participate in his care.

Caring for the *No Code* person is also listening, touching and being present. He often wishes to explore and attempt to work through his feelings about his dying, his death. Too often he is left in isolation and loneliness, by family and professionals, thinking thoughts that have been for a lifetime unthinkable. The nurse provides time to sit with the patient, to reflect and listen to his thoughts. Levine emphasizes, "Much of the emphasis on ethical issues in health care has been on life and death situations, dealing particularly with the definition of death and the distribution of limited life sustaining resources. But there are overlooked ethical challenges in the mundane, everyday routine activities of professional practice, and these have gone largely unexamined. Ethical behavior is not the display of one's moral rectitude in times of crisis. It is the day-by-day expression of one's commitment to other persons and the ways in which human beings relate to one another in their daily interactions."¹¹ Annas underlines the role of the nurse in talking to dying patients: "Nurses are both members of the health care team and professionals in their own right. It is both their legal and ethical duty to be honest with patients and respond to their questions to the best of their ability."¹² In so doing the nurse may assist the patient to open the door in his wall of loneliness and fear that allows him to honestly deal with himself, his family and his dying.

The patient's freedom from pain often depends directly on the accountability and sensitivity of the nurse. The physician posts in his orders, "Medicate, within a certain time period, as desired." The nurse assesses level of comfort, when to medicate and if to medicate. Pain assessment in this context is viewed as a complex process of data

collection that includes not only the subjective data elicited from the patient, but the ability to objectively assess with sensitivity the facial countenance, body position, social interaction and activity level. Levine says, "Every nursing relationship begins with an unusual burden of ethical responsibility. While the patient may have chosen his physician, he does not always have the option of choosing his nurse. The dependency of his patient-hood must be based on the assumption that he will be offered care that is at the very least, safe, effective, and morally responsible."¹³ Again, if the patient is coherent, it is his right to make the ultimate choice. He may wish to remain alert to facilitate continued interaction; or, he may wish to be medicated even at a loss to his mentation and/or shortening of his life. Reinforcing this approach, *The Ethical and Religious Directives for Catholic Health Care Facilities* state, "It is not euthanasia to give a dying person sedatives and analgesics for the alleviation of pain when such a measure is judged necessary, even though they may deprive the person of the use of reason or shorten his life."¹⁴

A caring and understanding touch and look convey a sense of belonging and safety. "All is well, you are living and dying with humanness, dignity, worth." Or, "It's all right, I know it's tough." The nurse continues to convey this by gentle care, warm conversation, and recognition of the patient by his name/position/family even as he slips into semi-consciousness.

So much gentleness and love is needed and freely given at the end. A seemingly unbending dictate is that no human being be allowed to die alone — and yet, God forgive us, so many do. Those last moments require of the nurse a very special sense of presence. So much is given — so much is gained. Recently on a large medical teaching unit an elderly gentleman was dying. His nurse turned him to make him comfortable and ready him for the long night ahead — he was dying! She left the room — perhaps in terror of dying — called his family and continued to care for other persons. A student nurse under the guidance of her instructor stepped in, sat with this gentleman, held his hand, assured him his family was coming and prayed with him. He rallied enough to convey his consciousness and the joy of being with a caring person. His family arrived; he died peacefully. Derek Bok, in a recent article, "Can Ethics be Taught?" comments on the potential access of the educator to the role of problem-solving facilitator and model in moral-ethical issues: "If other sources of ethical values have declined in influence, educators have a responsibility to contribute in any way they can to the moral development of their students."¹⁵

The family, also, needs support and guidance. Often, family members experience the burden of the issue and are torn with conflicting feelings. Their moral dilemma may resemble a seesaw that balances between the thoughts: perhaps more could be done to favor life;

perhaps more could be done to shorten the suffering and dying. Many families are lost in a barrage of kindly given but at times conflicting information that may be misunderstood and misinterpreted. Alternately, they may experience hope and then plunge into the deepest sadness. As an example, recently a *No Code* patient's family was told by one person that its loved one was clearly "slipping"; the next day it was informed by another person he was doing "quite well." The condition remained dismal. Consistent and realistic communication and support can be achieved by a nurse who strives to listen and intervene therapeutically with the patient and family and who consequently strives to share this approach and knowledge through interdisciplinary consultation, valid notes and nursing care plans.

One wonders how often a dying person has died alone. How often has he senselessly been isolated with his fears, gone hungry, remained in an uncomfortable position or experienced dehumanizing social contact? How often have the family/loved ones borne feelings of confusion, loss and guilt alone? This then is truly the ethical arena of the nurse.

As is evidenced by the preceding discussions, the ethical-moral problems inherent in modern health care delivery are becoming increasingly complex and difficult. Many of us admit freely to feeling overwhelmed and burdened by the ethical-moral dilemmas that confront us in our day-to-day practice. In an effort to bring nurses, physicians and ethicists together to discuss critical ethical issues, Newton Wellesley Hospital and Boston College are co-sponsoring a series of bioethics forums. The forums are structured to encourage dialogue between these groups, other interested health care providers and health care consumers. During each session a nurse, a physician and an ethicist present a short paper expressing their research and views regarding the chosen issue. A fourth panelist has contributed in each session from one of the following standpoints: law, theology, hospital administration, chaplaincy, health care, consumer. A discussion period (usually lively and lengthy) between the panel and audience follows the presentations.

A questionnaire was distributed to the professional nursing staff at Newton Wellesley Hospital, preparatory to the Bioethics Forum, "Orders Not to Resuscitate," sponsored by the hospital and Boston College. One hundred fifty questionnaires were delivered to the nursing units; thirty-five responses were completed and returned. The questions and the responses follow; they reflect the current general thought and practice of the respondents at Newton Wellesley Hospital.

1. In your experience, from what data is the decision *No Code* made?

A large majority of responses noted as crucial to the decision the quality of life prognosis (30). Family request (18), age (16), patient

request (9), physician (7), brain death (4) were also noted as significant determinants.

2. Ethically, who should make the decision *No Code*?

Respondents replied that ethically the *No Code* decision is made by the triad patient-family-physician (11), one response included input from the nurse, family and physician (10), one response included input from the nurse, patient and/or his designate with the physician (9), one response here alluded to the health team, physician (4), patient and family (1).

3. As a nurse, what is your role in the decision *No Code*? What do you believe could be your contribution in the *No Code* process?

Several (8) nurses felt they had no role or a limited role in the decision *No Code*. The remainder of the respondents described an advisory and supportive role. Physical and emotional care to the patient and family were viewed by (16) respondents as a major nursing contribution. Ten (10) mentioned interpretation of minute-to-minute data and perceptions of response to care as crucial. Ten (10) viewed communication of the patient and family's feelings about death as contributory to a conjoint interdisciplinary effort. The advocate role in pressing for the *No Code* status in terminal patients was mentioned (3), as well as the need to assure that the written order *No Code* is placed on the doctor's order sheet (2). One (1) respondent noted the need to observe for evidence to reverse the *No Code* status.

4. If you do not agree with the order *No Code*, what are your alternatives?

Nine (9) respondents indicated they had no alternative. Three (3) respondents would code the patient. Most responses described consultation with the attending physician to clarify goals (16), then recourse to assistance from the nursing supervisor (7), chief of medicine (1), and hospital administrator (1). Three (3) respondents noted the ultimate of refusal to participate in the care of the individual. The concept of an ethics consultant group was introduced by two (2) respondents.

5. If a patient is *No Code*, but certain problems remain treatable, e.g., hypotension, infection, anemia, how are these specifics conveyed to you and to the other nurses involved with the patient's care?

Respondents indicated several sources of care plans: written physician orders (10), verbal orders (6), progress notes (1), nursing kardex (2). Four (4) respondents expressed feelings of frustration and sadness in implementing plans that appear to prolong the dying and pain. Maintenance of the dignity of the dying person and comfort were overwhelmingly expressed as the most desired nursing objective (14).

6. In providing comfort for the *No Code* patient, is it ethically and morally reasonable to medicate even when such intervention may shorten his life?

All respondents (35) indicated an affirmative response as long as comfort was the directly sought effect.

7. In your experience, do you feel satisfied with the nursing care you are able to give the *No Code* patient and family?

Twelve (12) respondents felt satisfied, five (5) usually, one (1) dissatisfied. Five (5) respondents expressed feelings of discomfort and inadequacy with their ability to sensitively deal with the patient regarding his dying — death. Four (4) felt more time was needed to meet the many needs of the dying patient and his family. Five (5) felt discomfort at what appeared to be overzealous treatment of the *No Code* patient which confused health team goals.

The analysis of the questionnaire on the *No Code* issue reveals some interesting similarities and differences between current theoretical thought and current practice in care of the *No Code* patient. It is the hope that continued study in ethics and the sharing of theory and current practice modes may help us to better understand the issues and to better implement intervention strategies.

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