The Problem with Actually Tattooing DNR across Your Chest

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J Gen Intern Med 27(10):1238-9

DOI: 10.1007/s11606-012-2134-1

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No doubt JGIM readers have heard a clinician exclaim, after participating in a code or witnessing the suffering of a resuscitated patient, “I should have DNR tattooed across my chest!” For those individuals who strongly desire not to be resuscitated, the tattoo idea is appealing. By its nature, a tattoo implies a preference against resuscitation so strong that the person has etched the image onto their body. The tattoo is inseparable from the body. Unlike Do Not Resuscitate (DNR) paperwork or medic-alert bracelets, it cannot be misplaced, easily removed, or lost. Emergency responders are unlikely to miss seeing a DNR tattoo on the chest prior to attempting resuscitation.

To the extent that we should find ways of respecting persons’ deeply held preferences not to be resuscitated, we agree with the sentiment, if not the method. Clinicians are morally and legally obligated to respect the preferences of patients to forgo life-sustaining treatment.¹ The notion of a tattoo stems in part from fear that such choices will not be respected. This fear has a basis in reality — in the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), physicians only understood 46 % of hospitalized, seriously ill patients’ preferences to forgo cardiopulmonary resuscitation (CPR).² In qualitative interviews, emergency physicians described the emotional and moral distress caused by resuscitating a patient, only to learn later that the patient had a legal, signed, Do Not Resuscitate document that was not accessible in the emergency department.³

Actually tattooing DNR on one’s chest is intuitively appealing, but flawed as policy. Emergency responders and clinicians in health care settings are not obligated to respect a DNR tattoo. For a responsive patient, as in the story by Cooper and Aronowitz in this issue of JGIM,⁴ a tattoo should provoke a conversation about the patient’s goals, values, and preferences. For an unresponsive patient, a tattoo might provoke emergency providers to

search for a legally binding document, such as a Physicians Order for Life Sustaining Treatment (POLST) or a locally sanctioned pre-hospital DNR order — if there is time. But in a cardiopulmonary arrest, in the absence of such official documentation, the responding emergency provider or clinician should proceed with attempted resuscitation.

By imprinting the letters DNR on their body, a person obtaining a tattoo may wish to increase the certainty that their decision will be respected. Paradoxically, however, such a tattoo may exacerbate the uncertainty of emergency responders at a critical time. Legally sanctioned forms, such as the POLST, exist for a reason: they provide certainty for emergency responders who must be decisive about attempting or forgoing attempted resuscitation. A DNR tattoo, however, may cause confusion at the very moment when certainty is needed. First, its meaning may be ambiguous. The emergency responder may wonder: do the letters stand for Do Not Resuscitate? Or Department of Natural Resources? Or someone’s initials? Second, the tattoo may not result from a considered decision to forego resuscitation. Errors in interpretation may have life and death consequences. The tattoo in the case presented by Cooper and Aronowitz was the result of a badly conceived drinking game, not a statement of a deeply held conviction. The patient’s preferences actually were *for* attempted resuscitation. Third, a DNR order needs to be legally recognized in order to provide a legal safe harbor for first responders who implement it. In this case, if the emergency personnel had withheld CPR, they might be legally liable for an erroneous interpretation of the tattoo.

Finally, DNR orders, like all medical orders, need to be reversible. If patients are permanently committed to preferences expressed at one time, they may be reluctant to express any interest in foregoing interventions. Studies document that a substantial percentage of patients change their minds regarding preferences for attempted resuscitation.⁵ Circumstances change, and the literature suggests that people underestimate their potential for adaptation to illness and disability.⁶ Changing a POLST form or removing a DNR bracelet is fairly straightforward and free. Removing a tattoo, in contrast, is an expensive and time-consuming process. A call to a San Francisco tattoo removal clinic

suggests that laser removal of a tattoo of the size in the picture by Cooper and Aronowitz would cost on the order of \$150 a session, with an average of 8–10 sessions per tattoo, at a total cost of approximately \$1,500.

What can we learn from the DNR image in this case? Several things. First, DNR tattoos, and other forms of non-legally binding advance directives, are not to be trusted. Second, for those individuals who do hold strong preferences against resuscitation, there is a need for a form of legally binding documentation that is inseparable from the body. Twelve states, including California and New York, recognize the POLST form as legally binding orders to forego CPR and other resuscitation measures. These orders apply in all circumstances, including out-of-hospital, in skilled nursing facilities, in clinics and in hospitals. Local jurisdictions may have their own DNR forms that are legally recognized. To address the problem of POLST orders not being available to emergency responders and clinicians, Oregon created a registry so that when the physical form cannot be located, emergency responders and clinicians have 24-hour-a-day telephone access to POLST information.⁷ In the case of a cardiopulmonary arrest, however, first responders need to devote immediate attention to resuscitation efforts unless there is unambiguous evidence that the patient would not want CPR. Taking time to ascertain if the patient has a POLST order in the registry may decrease the likelihood of a successful

resuscitation. It is fitting that the state where the POLST form originated should lead the next wave of innovation in protecting the autonomous choices of individuals to forego life-sustaining interventions.

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