Peri-Operative Status of "Do Not Resuscitate" (DNR)* Orders and Other Directives Regarding Treatment

Canadian Anesthesiologists' Society
Committee on Ethics

* While the committee recognises that the literature is evolving towards the use of DNAR (Do Not Attempt Resuscitation), the more traditional terminology has been retained in this document.

1.0 Introduction

Patients with pre-existing DNR orders or other advance directives regarding treatment receive care from anesthesiologists during surgical and diagnostic procedures. Such directives may create ethical challenges and additional responsibilities for the anesthesiologist.[1]

Advance directives arise in one of two ways. Some patients will have recorded their decisions about future therapy in a written instructional directive and/or they may have appointed a proxy or substitute decision-maker to speak on their behalf, should they lose decision-making capacity. Other patients may have agreed to a DNR order or a level-of-intervention document following discussion and conversation with the health care professionals providing their care.

Regardless of the origin of the directive, the ethical principle of Respect for Persons ought to guide and inform decisions about resuscitative interventions.[2] Policies and practices that result in the automatic suspension or uncritical acceptance of DNR orders or other directives are inappropriate. The same principles apply when patients undergo invasive diagnostic or therapeutic procedures.[3, 4]

2.0 Guidelines

2.1 Review of DNR Order or Directive

Any DNR order and/or other directive must be reviewed before patients undergo anesthesia. The goal of this review is a shared decision that respects the wishes, interests, and values of the patient and the clinical judgement, expertise, and ethical obligations of the care provider(s). A transparent decision-making process will promote communication and trust between the patient and the care providers. The review should address the following issues:

1. Is the patient or designated substitute decision-maker aware of the DNR order?
2. Does the patient or designated substitute decision-maker understand the significance of the order?
3. What was the original meaning and intent of the DNR order or other directive unrelated to the proposed procedure?

   What exactly does the DNR order or directive mean to the patient or the patient's substitute decision-maker? For example, does a "no CPR" order or directive from a patient really mean "no CPR" under any circumstances or is it intended to have a more limited meaning, e.g., no CPR only if recovery is remote or there is no chance of recovery?
4. When, and in what context, was the DNR order or other advance directive put in place? Is the DNR or directive still relevant? Have the patient's circumstances changed sufficiently to warrant revising it?
5. Is the DNR order or other directive "location sensitive"?

   For example, some DNR orders or level-of-intervention documents for residents living in chronic care facilities may have been put in place because of the absence of timely CPR response mechanisms in that facility. These orders or level-of-intervention directives may not apply following transfer to an acute health care facility, where such limitations do not exist. They should be reviewed thoroughly with patients and/or designated substitute decision-makers.

Dialogue on all these issues with the patient and/or the patient's designated substitute decision-maker is essential. The goal is a clear, shared understanding of the order or directive in question.

2.2 Clarifying the peri-operative status of a DNR order or other directive regarding treatment

Following clarification of the nature of an existing DNR order or directive, further specific discussion with the patient or designated substitute decision-maker should occur with the intention of clarifying explicitly the status of the order or other directive with respect to proposed surgery or other invasive diagnostic or therapeutic procedures.

1. Review the specific anesthetic procedures required to carry out the proposed surgery or diagnostic procedure. Are they consistent with the meaning, intent, and shared understanding of the existing DNR order or directive?
2. If a cardiac arrest or other major adverse event were to occur as a consequence of surgery or a diagnostic procedure, but full recovery after immediate resuscitation could normally be anticipated, discuss whether the DNR order or other directive should be modified or suspended.
3. If a cardiac arrest were to occur in the peri-operative period, but not as a consequence of the surgical or diagnostic procedure, discuss whether the DNR order or other directive should remain in place.

3.0 Documentation and Communication

Following review of an existing DNR order or other directive, by mutual agreement between the patient and/or designated substitute decision-maker and the responsible care providers, decisions about the peri-operative status of such orders will usually fall into three general categories:

1. The pre-existing DNR order or other directive will continue unchanged throughout the peri-operative period.
2. The pre-existing DNR order or other directive will be suspended for an agreed-upon period of time — normally the entire peri-operative period.
3. The pre-existing DNR order or other directive will be revised and continue in a modified form, as agreed and recorded, throughout the peri-operative period.

The exact status of the peri-operative DNR order or other directive(s) should be clearly documented in the health record, including the intended duration of any modifications to the original order or directive.

4.0 Possible Exceptions to Mandatory Reconsideration

These guidelines may not be fully applicable in emergency situations where there is insufficient time to work through the required steps of a mandatory reconsideration. Even in an emergency context, however, every attempt should be made to clarify a pre-existing DNR order or other directive with a patient or designated substitute decision-maker.

If a pre-existing DNR order or other directive cannot be discussed with a patient or designated substitute decision-maker, care providers should make decisions that, to the greatest extent possible, protect and promote the interests of the patient.

5.0 Ethical Difference and Conflict Resolution

Patients, substitute decision-makers, and care providers may, in the course of discussing the status of a DNR order or other directive, experience uncertainty, personal conflict, or moral distress regarding their role in decision-making and/or the actual decision reached following the review of the order or directive. Guidelines to assist in the resolution of such issues have been published.[5]

In the event of ethical difference, the parties involved in the decision-making process will want to distinguish between two different situations:

1. The anesthesiologist may disagree with a decision or proposed course of action, yet will tolerate or accept the particular decision as an expression of respect for others who may have different beliefs and value commitments.
2. The anesthesiologist may disagree ethically with a decision or proposed course of action and choose not to co-operate because it would compromise his or her personal or professional integrity.[6] In this situation, the anesthesiologist should take steps to withdraw from the patient's care, but must also ensure alternative arrangements for that care with a colleague.[7]

References

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