



Honoring Do-Not-Resuscitate Orders during Invasive Procedures

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By the Kansas City Area Ethics Committee Consortium and the Center for Practical Bioethics

Healthcare facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) have been required to have written policies and procedures allowing patients to forgo cardiopulmonary resuscitation, so called “Do Not Resuscitate” (DNR) policies, since January 1988. However, questions have persisted about honoring DNR orders when a patient undergoes an operative or invasive procedure. Often in the past, DNR orders were disregarded under such circumstances. However, this approach is clearly incompatible with the goals and principles of the Patient Self-Determination Act of 1990. Patients’ legal and ethical rights to direct the course of their healthcare includes the right to refuse resuscitative procedures.

Most invasive procedures undertaken on patients with DNR orders are of limited duration and directed toward specific objectives; therefore, disregarding DNR orders during invasive procedures has been common. The rationale behind DNR orders acknowledges that the underlying disease will be allowed to take its course undeterred by medical intervention. Many anesthesiologists, surgeons, and physicians undertaking invasive procedures have felt a responsibility to treat any cardiopulmonary arrest their treatment may precipitate.

When a patient with a standing DNR order has an arrest during the course of an invasive procedure, these professionals often believe that their failure to treat the arrest is responsible for the death of the patient and that they will be held accountable for the death. Quality assurance and related policies must be adapted to reflect that when personnel undertake an invasive procedure on a patient with a DNR order, they are not

responsible for the death of such a patient if death results from withholding resuscitation.

It is also the case that many procedures undertaken in operating rooms can be classified as forms of resuscitation — such as intubation, the use of ventilators, and drugs to control heart rate and blood pressure. An arrest in the operating room or during the course of an invasive procedure may result from the use of anesthetic agents, the procedure itself, the underlying disease, or a combination of factors. The majority of these arrests can be promptly treated with no long-lasting or residual effects. Therefore, it is essential that a DNR order be reviewed and discussed prior to an invasive procedure. A critical aspect of this review is consideration of the patient’s rationale for the DNR order.

For example, if the patient is requesting a DNR order on the basis of an unacceptable quality of life, suspension of such an order during the invasive procedure may be inappropriate. On the other hand, if the refusal is based on consideration of the burdensomeness of resuscitative measures, suspension of the order may be appropriate since the burdensomeness of the procedure may be considerably reduced by anesthesia. Given the higher success rate of resuscitation undertaken during invasive procedures, especially when anesthesia is the presumed cause, a DNR order based on the futility of such resuscitation or fear of long-term ventilator dependence might also be reconsidered.

These issues have been identified and discussed by the Kansas City Area Ethics Committee Consortium sponsored by Midwest Bioethics Center. Incorporating recently published information and helpful guidelines regarding this problem, the

Consortium offers the following guidance.

Guidelines

1. These guidelines refer to cardiac and/or respiratory arrest that occurs inadvertently during an invasive procedure. Correcting this condition may require closed cardiac compression, artificial respiration, countershock, and other resuscitative measures.
2. A cardiac and/or respiratory arrest is a condition separate from that requiring the invasive procedure. Patients/surrogates who consent to anesthesia, surgery, or other invasive procedures may not necessarily consent to treatment of such an arrest.
3. Treatment for an arrest under these circumstances can, like other treatments, be accepted or refused by patients with capacity or by the appropriate surrogates of patients without decisional capacity. Healthcare providers have a responsibility to honor such acceptances or refusals.
4. Before a patient on DNR status undergoes an invasive intervention, at least one physician (surgeon, anesthesiologist, physician performing the invasive procedure, or the patient's attending physician) must engage in discussion with the patient or surrogate regarding the handling of the DNR order.

Discussion needs to include the original rationale for the DNR order as previously documented in the patient's medical record, information about the likelihood of requiring resuscitative measures, a description of these measures, the chance of success, and possible outcomes with and without resuscitation.

Salient features of this discussion must be documented in the progress notes section of the medical record. Either a DNR order or an order indicating that the

DNR order is suspended — including the period of time for which the order should be suspended — must be entered on the preoperative or pre-procedure order form.

5. If the patient wants the DNR order suspended during an operative or invasive procedure, the terms of the suspension must be discussed. The duration of the suspension of the DNR order may include the period during which the patient is in the operating room or undergoing the invasive procedure and the time when the patient is recovering from the procedure, for example, confinement in a recovery unit.

Some patients may wish to have their DNR order suspended for only part of this period. The discussion should also include procedures that may be necessary during this period such as short-term need for ventilatory support.

6. Communication regarding plans to honor a DNR order in this situation must take place among all staff involved in the procedure. A patient's surrogate's decision to refuse resuscitation during an invasive procedure is compatible with maximal therapeutic efforts. This decision does not imply limits on any other forms of care, such as intensive care.

Bibliography

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This guideline has not been reviewed since 1997. Please be advised that in January 2014, the American College of Surgeons issued its updated and revised "Statement on Advance Directives by Patients: Do Not Resuscitate" in the Operating Room." Readers of the Consortium document should access the ACOS revised statement for additional considerations that may have relevance. Please see more at <https://www.facs.org/about-ac/s/statements/19-advance-directives>

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