ANESTHESIA CARE FOR PATIENTS WITH “DO NOT RESUSCITATE” ORDERS: CONFRONTING THE PARADOX

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Abstract

Patients coming to the perioperative setting with “Do Not Resuscitate” orders on their charts present an interesting situation for anesthesiologists and nurse anesthetists entrusted with their care. While anesthesia professionals may consider the existence of such orders to be in contradiction to their professional obligations to the patient, such orders must be carefully reconsidered by patient or surrogate and anesthesia professional prior to the induction of anesthesia.

Professional concerns of anesthesiologists and anesthetists over the management of perioperative patients in acute care hospitals have led to some interesting considerations of the notion of patient autonomy as traditionally recognized in the United States.

A long accepted outgrowth of patient autonomy and medical facility is the DNR or “do not resuscitate” order which is frequently entered on hospitalized patients who are terminally ill or permanently unconscious. The order usually follows the wishes of a patient as previously expressed in a living will or the wishes of a legally recognized surrogate who may be the holder of a durable power of attorney for health care or a court ordered guardianship appointment. According to traditional American legal authority, a surrogate’s decision should be based upon “substituted judgment,” meaning that the surrogate should decide as he or she believes the patient would have decided if the patient was legally capable of making such a decision. Even in the absence of the patient’s previous expression in a living will, a DNR can usually be entered on a patient after a thorough consideration of the patient’s prognosis and discussion between the attending physician and the patient, if capable, or surrogate if the patient is incapable.

The DNR order, which must always be specifically entered on the patient’s chart by the physician regardless of any previous statements contained in a living will, specifies the response to be taken by the patient’s caregivers in the event that the patient experiences a cardiac arrest. Some DNR orders specify that no resuscitative measures be undertaken in the event of an arrest, while others list certain limited means of resuscitation that may be undertaken.

The professional concerns of anesthesiologists and anesthetists regarding the status of DNR orders on patients in the preoperative setting prompted acute care hospitals in the United States to revisit hospital policies and procedures regarding the honoring of DNR orders. The vast majority of DNR orders are initially entered on patients while they are being cared for...
on medical floors of acute care hospitals, and in many cases, no subsequent time-limited intervention is anticipated in the patients plan of care.

The dilemma of anesthesia may be summarized as: what becomes of the DNR order if the patient is brought to the perioperative or other specialized setting? Anesthesiologist physicians and nurse anesthetists are accustomed to managing the patient while under anesthesia, and that patient management traditionally has meant resuscitating the patient, if need be, during or immediately after the intervention. In many cases, the physiologic effect of administering the anesthesia causes the need for resuscitation.

Those who administer the anesthesia, and who have responsibility for the anesthetized patient, argue that the imposition of a DNR order conflicts with their professional responsibilities. They claim that if they are to administer anesthesia, they must have the ability to resuscitate the patient from the effects of anesthesia, or from any arrests triggered by other causes while the patient is under their care. As a practical matter, it is extremely difficult to distinguish between those arrests caused by the administration of anesthesia and those arrests stemming from other causes while the patient is anesthetized. The following sections highlight some practical issues faced by acute care hospitals in attempting to balance the interests of patients who have expressed their wishes for the provision of care under limited prognosis with those of anesthesia professionals who see an obligation to resuscitate patients who are under their care.

1. Rescind DNR Orders For Perioperative Patients

One of the earliest responses to the perceived conflict was for hospitals to promulgate operating policies which specified that DNR orders were suspended when patients were anesthetized. Such policies usually acknowledged the risks involved in the administration of anesthesia and the likelihood of the need for resuscitation under certain circumstances during or immediately after anesthesia. The issuance of such institutional policies usually gave great comfort to anesthesiologists and anesthetists concerned about the performance of their duties in light of previously entered DNR orders.

But while such policies addressed the concerns of the anesthesia professionals, in many instance the policies overlooked the right of patients and surrogates to specify their wishes regarding resuscitative measures.

In support of such policies, anesthesiologists and anesthetists argued that they could not be restricted in the performance of their duties by being expected to honor DNR orders which had been entered before a need for other interventions arose. They claimed that their professional obligations required them to be able to resuscitate their anesthetized patients. Some even argued that if patients wanted their DNR orders honored they should not expect to undergo surgery or certain other treatments requiring anesthesia.

From the patient’s and surrogate’s perspective, the initial entry of a DNR order grew out of an informed consent process in which they reviewed the risks, benefits and alternatives of such care with an attending physician. If a
hospital unilaterally suspends the honoring of a DNR by policy, then it has, in essence, over-ridden the patient or surrogate's wishes as previously agreed to when the DNR order was initially entered.

However, if the anesthesia professional has discussed the implications of the DNR order during surgery with the patient or surrogate and they mutually agree to a suspension of the DNR order during anesthesia, then arguably the suspension is not unilateral on the part of the anesthesia professionals and hospital, but rather a mutual decision by patient or surrogate and caregiver as a result of a subsequent informed consent exercise.

2. **Allow the Anesthesia Professionals to use their Professional Judgment as to the Appropriateness of Resuscitation**

In addressing the concerns of patients and surrogates who are unwilling to agree to a complete suspension of a DNR order during anesthesia, some institutions have developed “professional judgment” policies under which patients and surrogates can consent to having the anesthesia professionals decide whether or not resuscitation will be employed while the patient is anesthetized (1).

On their face, such policies would appear to attempt to address the distinction between episodes of arrest that are an outgrowth of the administration of anesthesia and those which are triggered by another physiologic cause. The implicit rationale underlying such a policy is that a patient or surrogate would agree to having resuscitation if the arrest was caused by the administration of anesthesia, but would not want resuscitation if the arrest was not caused by the anesthesia.

As previously stated, it is extremely difficult clinically to attempt to determine whether the cause of an arrest in an anesthetized patient is anesthesia-related or not. In the event of doubt as to the cause, the anesthesia professional could be expected to err on the side of caution by initiating resuscitation. The end result would be the same as if the patient had agreed to a suspension of the DNR during anesthesia.

However, if the patient’s or surrogate’s decision to abide by the decision of the anesthesia professional as to the appropriateness of resuscitation is an outgrowth of the informed consent process, it would seem ethically and legally valid.

3. **Respect the Good Conscience Decisions of the Anesthesiologists and Anesthetists**

Somewhat similar to the concept of allowing anesthesia professionals to use their professional judgment in making decisions on the care of DNR patients undergoing anesthesia, allowing those professionals to follow the dictates of their own consciences gives them wide-ranging discretion in their decision making. But rather than focusing the decision making efforts on the time period while the patient is under the influence of anesthesia, the conscience based alternative allows the anesthesia professionals the opportunity to decide in advance whether or not to administer anesthesia to a patient who does not wish to rescind their DNR order.

Allowing such discretion closely mirrors the exceptions for conscience provisions of state laws governing
controversial ethical issues such as end of life decision making. Such statutory provisions enable individual caregivers to refuse to participate in individual episodes of care based upon their conscientious objectives. Many health care institutions have administrative policies emphasizing the rights of caregivers to make such decisions.

But while individual caregivers may have the right to excuse themselves from the provision of care to specific patients under certain circumstances, the hospitals within which those caregivers work usually have a corresponding obligation to see that the legitimate wishes of their patients are honored. That is, the anesthesia professional may decline to provide care in conformity with an individual patient’s wishes, but the hospital may have ethical and legal obligations to see that the same wishes are honored. If certain individuals are to be excused from rendering care in certain instances, the hospital may find itself with the obligation to insure that professionals without the same reservations of conscience are available to render care in accordance with the patient’s wishes.

For example, in most US acute care hospitals, practicing anesthesiologists, and sometimes nurse anesthetists, are members of independent groups which provide anesthesia services to hospital patients subject to a contract between the group and the hospital. Generally, such contracts provide that the group will meet all of the hospital’s anesthesia care needs in return for the right to bill for and receive the professional reimbursement paid for the care of such patients. Such a contract would enable a hospital to guarantee that while individual anesthesia professionals may excuse themselves from the care of certain patients, the group commits to provide anesthesia care to all hospital patients requiring such care. Implicitly or explicitly, the group agrees to provide substitute coverage for those members who wish to excuse themselves based upon decisions of conscience.

4. Require Reconsideration of DNR Orders by Patients or Surrogates Before the Induction of Anesthesia

A sound alternative to the anesthesia–DNR dilemma is to require that DNR orders be reconsidered in those hospital settings “… where discrete, time-limited therapies with the potential to precipitate cardiac arrest are offered (2).” In addition to the operating room, such settings might also include electro convulsive treatment (ECT), bronchoscopy, cardiac catherization and hemodialysis.

Under a policy of required reconsideration, the anesthesiologist, or possibly the treating physician or surgeon, would enter into an informed consent dialogue with the patient or surrogate about the measures to be taken in the event that the patient experiences a cardiac arrest during treatment. If the patient or surrogate decides to suspend the DNR order in the perioperative period, the circumstances under which the order is to be reinstated are documented in the medical record. Likewise, if the decision is made to retain the DNR order, the nature of the resuscitative measures to be withheld should also be documented.

By requiring reconsideration of the DNR order prior to the initiation of the
time-limited treatment, the patient or surrogate has the further opportunity to specify, immediately prior to the treatment which may lead to cardiac arrest, his or her wishes regarding resuscitation. The anesthesia professionals also have the security of knowing that the patient or surrogate specifically addressed the issue of resuscitation in immediate contemplation of the very treatment during which cardiac arrest may be experienced.

References