Peri-Operative Status of "Do Not Resuscitate" (DNR)* Orders and Other Directives that Limit Interventions

Canadian Anesthesiologists' Society Committee on Ethics

1.0 Introduction

Patients with pre-existing DNR orders or other advance directives regarding treatment limitations receive care from anesthesiologists during surgical and diagnostic procedures. Such directives may create professional and ethical challenges and cause 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 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. On these aspects, the anesthesiologist should be familiar with the policies and legal procedure applicable to the situation.

Regardless of the origin of the directive, it serves as an extension of the patient's autonomous decision making and is meant to provide the healthcare team with guidance that informs about resuscitative interventions. [2] The context of a proposed intervention adds important information to any pre-existing advance directive. Therefore, policies and practices that result in the automatic suspension or uncritical acceptance of DNR orders or other directives are inappropriate.

2.0 Guidelines

2.1 Review of DNR Order or Directive

Any DNR order and/or other directive should be reviewed before patients undergo anesthesia. [3,4,5] This review is part of the process of informed consent and its goal is a shared decision that respects the wishes, best interests, and values of the patient. The role of substitute decision makers in these discussions is to be the voice for the patient; helping the healthcare team to understand the intent of an advance directive. As a shared decision the clinical judgement, expertise, and ethical obligations of the care provider(s) are important aspects that help inform this review. A transparent decision-making process will promote communication and trust between the patient/substitute decision-maker and the care providers. In many circumstances it may be important to consider the involvement of other care providers who have been involved in prior discussions about an advance directive; this broader consultation may include the primary care physician, pertinent specialists, and palliative care. These caregivers can provide necessary context and also support a patient and family through challenging decision-making.

The review itself 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.

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 management required to care for the patient during the proposed surgery or diagnostic procedure. Review the anticipated impact of the patient's pre-existing condition(s) on the conduct of the procedure and the range of possible outcomes. Are the management and proposed procedures consistent with the meaning, intent, and shared understanding of the existing DNR order or directive?
2. If a cardiac arrest or major adverse event were to occur within the perioperative period but full recovery after immediate resuscitation could normally be anticipated, discuss whether the DNR order or another directive should be modified or suspended.

3.0 Pediatric Considerations

Pediatrics represents a special case as it concerns limitations of care and DNR orders. As with adults, it is recommended to review any current DNR or limitation of care that is in place as part of the consent process for an intervention. [6] While children often have decisions made for them by their parent or tutor, in some jurisdictions in Canada there is no lower age limit for being designated as a mature minor. The capacity to provide consent is most often assessed on a case-by-case basis that takes into account the context-sensitive details of the decision that is being made. This approach is compatible with the current neuroscientific literature regarding adolescent brain development [7] and takes into consideration the minor's lived experience and ability to appreciate the risks and consequences attached to a particular decision. It is important to be familiar with relevant provincial/territorial legislation.[8] For children not yet meeting the standard of a mature minor it is still possible that their preferences and values may play an important role in helping inform a discussion seeking to review any limitations in care, particularly when pediatric best interests in a given case are not clear. [9] In many cases though, it is the parents/caregivers/legal tutors who have the responsibility of working with the team to evaluate their child's best interests in the context of the proposed intervention.

4.0 Documentation and Communication

Following review of an existing DNR order or other directive, by mutual agreement between the patient or 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 another 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 should be clearly documented in the health record, including the intended duration of any modifications to the original order or directive. During these discussions it is important to clarify the exact meaning of perioperative period. Does the status of the perioperative DNR or other directive extend to PACU, ICU, the ward, or to discharge? The status of the DNR or other directive should always be open to further discussion in the event of any change in the patient's status during the perioperative period. Following the perioperative period these discussions need to be revisited to ensure that any DNR or other directive continues to accurately capture any changes in the patient's status and/or preferences that may result in modifications of the document.

5.0 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 best interest of the patient.

6.0 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 [10] and vary from province to province. In the event of ethical difference, the parties involved in the decision-making process will want to distinguish between three 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. [11] 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. [12]
3. The limitations on care may be judged to either seriously impact the safe conduct of a procedure, or not align with the goals of the proposed procedure. In this case it may be judged necessary by the healthcare team to either modify or not proceed with the intervention. It may also be the case that the healthcare team may feel that the best interests of the patient are not being properly represented by the substitute decision maker. In any of these circumstances, disputes between the team and the patient/substitute decision maker may arise. Dispute resolution processes are helpful and local approaches will vary. It is important to understand the policies and processes in place at each institution and enact them when necessary.

*The committee recognises that the terminology around limitations of care is varied. In many settings, resuscitative interventions and their limitations are broken down into categories that further differentiate the range of possible measures that are available. This reflects a more nuanced approach towards aligning interventions with patient-centered goals of care that consider the patient's values, underlying medical condition and reasonable expectations of reversibility to a state that is acceptable to the patient. There is currently a lack of Canadian standards with regards to the documentation utilized to capture a patient's advance directives regarding consent/withholding of consent to resuscitation. For the purposes of this document the more traditional terminology has been retained for the sake of brevity.

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