DNR IN THE OR: ETHICS FOR ANESTHETISTS

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York College of PA/WellSpan Health
Nurse Anesthetist Program Class of 2016
BACKGROUND

- Commercial Interests
  - None!

- Professional Background
WHY ETHICS?

- It is your professional obligation

American Association of Nurse Anesthetists
222 South Prospect Avenue
Park Ridge, IL 60068
www.aana.com

Code of Ethics for the Certified Registered Nurse Anesthetist

1. Responsibility to Patients
   CRNAs preserve human dignity, respect the moral and legal rights of health consumers, and support the safety and well being of the patients under their care.
WHY ETHICS?

- It is your obligation to society

GUIDELINES FOR THE ETHICAL PRACTICE OF ANESTHESIOLOGY

Committee of Origin: Ethics

(Approved by the ASA House of Delegates on October 15, 2003, last amended on October 19, 2011, and reaffirmed on October 16, 2013)

PREAMBLE

Membership in the American Society of Anesthesiologists is a privilege of physicians who are dedicated to the ethical provision of health care. The Society recognizes the Principles of Medical Ethics of the American Medical Association (AMA) as the basic guide to the ethical conduct of its members.

AMA Principles of Medical Ethics (2001)

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals and to self. The following Principles adopted by the American Medical Association are not laws but standards of conduct which define the essentials of honorable behavior for the physician.
### U.S. Views on Honesty and Ethical Standards in Professions

Please tell me how you would rate the honesty and ethical standards of people in these different fields -- very high, high, average, low, or very low?

<table>
<thead>
<tr>
<th>Profession</th>
<th>% Very high or high</th>
<th>% Average</th>
<th>% Very low or low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>80</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>Medical doctors</td>
<td>65</td>
<td>29</td>
<td>7</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>65</td>
<td>28</td>
<td>7</td>
</tr>
<tr>
<td>Police officers</td>
<td>48</td>
<td>31</td>
<td>20</td>
</tr>
<tr>
<td>Clergy</td>
<td>46</td>
<td>35</td>
<td>13</td>
</tr>
<tr>
<td>Bankers</td>
<td>23</td>
<td>49</td>
<td>26</td>
</tr>
<tr>
<td>Lawyers</td>
<td>21</td>
<td>45</td>
<td>34</td>
</tr>
<tr>
<td>Business executives</td>
<td>17</td>
<td>50</td>
<td>32</td>
</tr>
<tr>
<td>Advertising practitioners</td>
<td>10</td>
<td>44</td>
<td>42</td>
</tr>
<tr>
<td>Car salespeople</td>
<td>8</td>
<td>46</td>
<td>45</td>
</tr>
<tr>
<td>Members of Congress</td>
<td>7</td>
<td>30</td>
<td>61</td>
</tr>
</tbody>
</table>

Dec. 8-11, 2014
Rated in order of % Very high or high

It is your obligation to yourself

Moral Distress in Certified Registered Nurse Anesthetists: Implications for Nursing Practice

Linda Clerici Radzvin, RN, PhD, CRNP

Registered nurses are frequently confronted with ethical dilemmas in their nursing practice. As a consequence of their decisions regarding ethical challenges, nurses report experiencing moral distress. This experience is often manifested by such feelings as anger, guilt, and sadness, and has been identified as a contributing factor to burnout and turnover in nursing.

The purpose of this exploratory, descriptive study was to determine if Certified Registered Nurse Anesthetists (CRNAs) experience moral distress in their nursing practice. A random sample of 800 CRNAs from the registry of the American Association of Nurse Anesthetists was selected to participate in this study. Participating nurses were asked to complete a demographic data survey and the Ethics Stress Scale. Three hundred surveys were analyzed for this study.

The data supported the assumption that CRNAs do experience moral distress in their nursing practice. Although a small number of nurse anesthetists experienced high levels of moral distress, CRNAs generally experienced moderate levels of moral distress. Moral distress was associated with situations in which anesthetists believed they were aware of the morally correct course of action but were unable to follow through with these behaviors. Also, CRNAs reported physical and psychological manifestations in relation to moral distress.

Keywords: CRNAs, moral distress, nurses.
What causes moral distress for CRNAs?

- “the delivery of aggressive care to patients who will not benefit from that care,
- ignoring the wishes of patients regarding treatment,
- working with unsafe levels of nursing staff,
- and working with incompetent physicians.”
Which CRNAs experience the most moral distress?

- “it appears that younger nurse anesthetists may lack ethical decision making experience and, as a result, encounter greater moral distress when faced with ethical dilemmas.”

- “CRNAs with lesser years of experience had higher moral distress, which increased with increasing experience.”
Your chosen profession demands a high level of ethical decision making

Patients expect you to be an expert

Ethical decision making can be emotionally and physically draining – take care of yourself
OBJECTIVES

- Describe the ethical framework for end-of-life decision making

- Understand the process of “required reconsideration” for surgical patients with DNR orders

- Describe the characteristics and perspectives of surgical patients with DNR orders, including strategies for conducting difficult conversations
Advanced Directives

- Living Will
  - Specifies which life-sustaining treatments a patient wishes to receive or forgo
  - Can be filled out by anyone; need two witnesses
  - Applies only when a physician deems the patient no longer capable of making decisions for him- or herself and
    - that the patient has an end-stage medical condition or
    - that the patient is permanently unconscious
  - Can be revoked by the patient at any time, even at end-of-life
  - Only competent adults and emancipated minors can make a living will

- Durable Power of Attorney for Healthcare
  - Designates a surrogate decision maker in case the patient cannot make or communicate his or her own treatment decisions
  - Can be filled out by anyone, but it is recommended that a lawyer helps draft it
What is a DNR order?

- A medical order to withhold CPR in the event of a cardiac or respiratory arrest
- Applies only to the unresponsive, clinically pulseless patient
- May also be called DNAR (do not attempt resuscitation) or AND (allow natural death)
- May or may not be accompanied by DNI order (do not intubate)
- May be indicated as part of an advanced directive or ordered by a physician after a documented conversation with the patient or the patient’s legal representative
- The patient does not need to have an advanced directive to have a DNR order!
Should we ask all surgical patients about their advanced directives?

A retrospective analysis of 250 hospitals participating in the American College of Surgeons National Surgical Quality Improvement Project 2005-2010

Total of 1.3 million surgical cases reviewed; looked at those requiring CPR with BLS or ACLS within 30 days of the operation
OUTCOMES

- 6,382/1.3 million surgical patients required CPR within 30 days of the operation (1/203)
## OUTCOMES

### Table 4. Incidence of CPR by Surgical Specialty, ACS-NSQIP (2005-2010)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>No. of CPR Cases</th>
<th>Incidence of CPR in ACS-NSQIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Incidence, %</td>
</tr>
<tr>
<td>Cardiac</td>
<td>240</td>
<td>3.0</td>
</tr>
<tr>
<td>General</td>
<td>3713</td>
<td>0.387</td>
</tr>
<tr>
<td>Gynecology</td>
<td>25</td>
<td>0.06</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>55</td>
<td>0.268</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>141</td>
<td>0.169</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>31</td>
<td>0.169</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>15</td>
<td>0.098</td>
</tr>
<tr>
<td>Thoracic</td>
<td>91</td>
<td>1.14</td>
</tr>
<tr>
<td>Urology</td>
<td>49</td>
<td>0.172</td>
</tr>
<tr>
<td>Vascular</td>
<td>2022</td>
<td>1.31</td>
</tr>
<tr>
<td>Overall</td>
<td>6382</td>
<td>0.492</td>
</tr>
</tbody>
</table>

Abbreviations: ACS-NSQIP, American College of Surgeons–National Surgical Quality Improvement Program; CPR, cardiopulmonary resuscitation.
86% of the cardiac arrests occurred post-op; only 0.07% occurred intra-op

Overall 30-day mortality in the entire data set was 1.7%; Patients who received CPR had a mortality rate of 71.6% (p<0.001)
It is rare for surgical patients to experience an intra-operative cardiac arrest...

...however, ~1 in 200 surgical patients have a cardiac arrest within 30 days of surgery

Surgical patients that experience a peri-operative cardiac arrest are likely to die within 30 days of the cardiac arrest (70% mortality rate)

Talk about advanced directives!!

Often, in pre-op the patient’s loved ones are present
The Advanced Directive Process at York

- Legally, we are required to ask all patients on admission if they have an advanced directive: yes or no question.
Summary of the Patient Self-Determination Act from the Commission on Law and Aging at the ABA

SUMMARY OF THE PATIENT SELF DETERMINATION ACT

The Patient Self Determination Act (PSDA) of 1990 was introduced by Senators Danforth and Moynihan (S. 1766) and by Congressman Sander Levin (H.R. 5067). It was enacted on November 5, 1990, as Section 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L. 101 508, and codified at 42 U.S.C. Sections 1395cc(a)(1)(Q), 1395mm(c)(8), 1395cc(f), 1396a(a)(57),(58), and 1396a(w). Technically, the "Act" is merely an amendment to federal Medicare and Medicaid law; nevertheless, it is popularly referred to as an Act. The Act does not substantively change health care decisions law; it is primarily an information and education mandate.

Effective December 1, 1991, the Act required all Medicare and Medicaid provider organizations (specifically, hospitals, skilled nursing facilities, home health agencies, hospices, and prepaid health care organizations) to do five things:

1. "provide written information" to patients at the time of admission concerning "an individual's right under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives";

2. "maintain written policies and procedures" with respect to advance directives (e.g., living wills and health care powers of attorney) and to inform patients of the policies;

3. "document in the individual's medical record whether or not the individual has executed an advance directive"

4. "ensure compliance with the requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization"; and

5. "provide (individually or with others) for education for staff and the community on issues concerning advance directives."

The Act also requires providers "not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive."

The Advanced Directive Process at York

- Legally, we are required to ask all patients on admission if they have an advanced directive: yes or no question.

- If they say no, we have to “provide written information” - an information booklet.

- There is no legal requirement to have a discussion about advanced directives, or end of life wishes; this discussion is left up to the providers.
1. What is the prevalence of DNR orders among surgical patients?

2. Which surgeries are commonly performed on DNR patients?
Medical conditions that may require anaesthesia for operative interventions in a patient with a DNAR decision include:

- provision of a support device (e.g. a feeding tube)
- urgent surgery for a condition unrelated to the underlying chronic problem (e.g. acute appendicitis)
- urgent surgery for a condition related to the underlying chronic problem but not believed to be a terminal event (e.g. bowel obstruction)
- procedure to decrease pains (e.g. repair of fractured neck of femur)
- procedure to provide vascular access

From Do Not Attempt Resuscitation (DNAR) Decisions in the Perioperative Period, published by The Association of Anaesthetists of Great Britain and Ireland
CASE STUDY

- 71 y/o female with colon cancer presents for a low-anterior resection at York Hospital

- Post-op, admitted to ICU; she develops a surgical site infection and sepsis over the following week

- Intubated, sedated, unresponsive

- Patient has a DNR order documented in the chart

- After two weeks in the ICU, the team recommends trach/PEG

- You are sent to pre-op the patient!
What ethical principles should guide your conversations with this patient’s family?

- Beneficence
- Nonmaleficence
- Justice
- Respect for Autonomy

“The rights of an individual to have control over their own body and to be allowed to make decisions about their medical treatment are paramount.” — From *Do Not Attempt Resuscitation Decisions in the Perioperative Period* by The Association of Anaesthetists of Great Britain and Ireland
Should a DNR order be automatically suspended in the peri-operative period?

- Reasons to suspend the DNR order
- Reasons to continue the DNR order
1. Full attempt at resuscitation
   - Fully rescind the DNR order and make full resuscitation attempts during the anesthetic and immediate post-op period

2. Limited attempt at resuscitation defined with regard to specific procedures
   - Leave the DNR order in place during the peri-operative period, and only provide anesthesia that is compatible with the patient’s/family’s wishes

3. Limited attempt at resuscitation defined with regard to the patient’s goals and values
   - Allow the surgical team, including the anesthetist, to use their clinical judgment about which resuscitative procedures are appropriate, keeping the patient’s/family’s goals and values in mind
I. Given the diversity of published opinions and cultures within our society, an essential element of preoperative preparation and perioperative care for patients with Do-Not-Resuscitate (DNR) orders or other directives that limit treatment is communication among involved parties. It is necessary to document relevant aspects of this communication.
Because York Hospital desires to honor a patient’s right to self-determination in a responsive and ethical manner, it is not appropriate for no-resuscitation orders or other directives that limit treatment to be automatically or routinely suspended during the perioperative period. Instead, any such suspension should only be made based upon evaluation and discussion of the patient’s unique circumstances and preferences, and upon agreement among the patient (or his surrogate, if appropriate) and relevant providers.

It is recognized that, even in those situations where a decision has been made to allow a patient to die a natural death that results from the patient’s underlying condition, it may be clinically and ethically appropriate for the patient and providers to decide to suspend existing no-resuscitation orders for a period of time and provide resuscitation or other life-supportive care to a surgical patient who experiences a potentially reversible cardiopulmonary arrest that results from anesthesia or the operative procedure itself.

The process of reevaluating and, where appropriate, suspending no-resuscitation orders during the perioperative period should be a collaborative process based upon discussions among the patient (or his surrogate, if appropriate), the surgeon (who has primary responsibility), the anesthesia provider, and perhaps the provider who wrote the no-resuscitation order. These discussions should occur prior to the operative procedure, and should be documented in the patient’s medical record, preferably as part of the informed consent discussion of risks, benefits, and alternatives to the operative procedure and related anesthesia. It is recommended that the operative/anesthesia consent form(s) should be modified to specifically address suspension of no-resuscitation orders.

If any one or more of the surgical or anesthesia providers are unable to agree with the patient (or his surrogate, if appropriate) and do not wish to proceed with the surgery or related anesthesia without suspension of an existing no-resuscitation order, that provider should withdraw from the case and offer to assist with making alternative arrangements including referring the patient to other providers (if any) who may be willing to honor the patient’s wishes. If such a provider is concerned whether decisions are being made in the best interests of the patient, he may choose to consult with the Ethics Committee.
Team recommends trach/PEG
Pt has a DNR order
Recommendations:
  - Talk to the family
  - Elicit goals of surgery and end-of-life goals
  - Present the three options of required reconsideration
    - fully rescind DNR order
    - rescind DNR order but leave resuscitation decisions up to surgical team
    - leave DNR order in place
  - Respect the family’s decision!
CASE STUDY 2

Video
Dorothy Glass, 85 y/o.

**PMH:** Hep C, cirrhosis, liver cancer, esophageal varices, CHF (EF 35%), depression, arthritis

**PSH:** EGD with banding 11/2014, Right THA (2001), Tubal ligation (1972)

**HPI:** Pt had syncopal episodes in her nursing home. Went to the ED, diagnosed with sick sinus syndrome. Cardiology recommends a pacemaker/ICD.

You are sent to pre-op the patient!
LIVING WILL

(HEALTH CARE INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS)

* This model Living Will form was developed by health care providers to assist you in documenting your health care instructions and preferences. You may use a different Living Will form, if you prefer. Other examples of Living Will forms are available at:

www.agingwithdignity.org/5wishes.html
www.aging.state.pa.us/aging/lib/aging/AdvanceDirectives.pdf

* In addition to this Living Will form, it is strongly recommended that you also designate a trusted person to be your surrogate decision-maker, in case you become unable to make or communicate treatment decisions for yourself. You can name a surrogate decision-maker by completing a Durable Power of Attorney for Healthcare form, which is available from WellSpan Health.

The following health care instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my preferences to be followed if I become unable to make or communicate treatment decisions for myself.

IF I HAVE AN END-STAGE MEDICAL CONDITION (WHICH WILL RESULT IN MY DEATH, DESPITE THE INTRODUCTION OR CONTINUATION OF MEDICAL TREATMENT) OR I AM PERMANENTLY UNCONSCIOUS (SUCH AS AN IRREVERSIBLE COMA OR AN IRREVERSIBLE VEGETATIVE STATE) AND THERE IS NO REALISTIC HOPE OF SIGNIFICANT RECOVERY, I DIRECT MY HEALTH CARE PROVIDERS AND MY SURROGATE DECISION-MAKERS (INCLUDING MY HEALTH CARE AGENTS OR REPRESENTATIVES) TO BE GUIDED BY THE FOLLOWING INSTRUCTIONS:

1. I direct that I be given health care treatment (which could include medications and/or procedures) to relieve my pain or keep me comfortable, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

2. I direct that any health care treatment that is given primarily for the purpose of prolonging my life (for example, heart-lung resuscitation/CPR, mechanical ventilation, or kidney dialysis) be withheld or withdrawn.

3. I direct that any health care treatment that might otherwise be life-prolonging may be given to me if my health care providers decide that such treatment will relieve my pain or keep me comfortable, or could effectively provide medical benefit to me (for example, radiation therapy for relief of bone cancer, or antibiotics for treatment of fever).

4. I understand that Pennsylvania law presumes that I want nutrition (food) or hydration (water) to be medically supplied to me by a tube into my nose, stomach, intestine, arteries, or veins, unless I specify otherwise. To specify that you do NOT want nutrition (food) or hydration (water) to be medically supplied to you by a tube, please initial the following statement:

   [ ] I direct that if I have an end-stage medical condition or I am permanently unconscious and there is no realistic hope of significant recovery, I do NOT want nutrition (food) or hydration (water) to be medically supplied to me by a tube.

(continued on other side)
What are the outcomes of DNR patients that go to the OR?

A retrospective analysis of 120 hospitals participating in the American College of Surgeons National Surgical Quality Improvement Project 2005-2008

Total of 4128 DNR patients matched with 4128 non-DNR patients
Mean age: 79.1 years  
Most patients were female (58.2%) and white (81.5%)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>DNR Order</th>
<th>No DNR Order</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost independent functional status between illness onset and day of surgery</td>
<td>27.1%</td>
<td>12.8%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Number of comorbidities</td>
<td>4.3</td>
<td>3.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Intra-op MI, cardiac arrest, unplanned intubation</td>
<td>0.8%</td>
<td>0.6%</td>
<td>0.43</td>
</tr>
<tr>
<td>Complication rate</td>
<td>31%</td>
<td>26.4%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Number of complications</td>
<td>1.9</td>
<td>2</td>
<td>0.70</td>
</tr>
<tr>
<td>Died within 30 days of surgery</td>
<td>23.1%</td>
<td>8.4%</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
Not all do-not-resuscitate (DNR) orders are the same: outcomes of 4738 elderly surgical patients who instituted a DNR order at hospital admission.

**Methods:**
- 104,752 abdominal surgery patients from 2008-2010
- 65 years old or older
- Instituted a DNR order within 24 hours of hospital admission

**Results:**

<table>
<thead>
<tr>
<th></th>
<th>DNR Order</th>
<th>No DNR Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complication Rate</td>
<td>64%</td>
<td>40%</td>
</tr>
<tr>
<td>Post-op ventilation</td>
<td>21%</td>
<td>9%</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Tube Feeds</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Death</td>
<td>21%</td>
<td>4%</td>
</tr>
</tbody>
</table>

*Half of deaths among DNR patients occurred < 10 days from admission.*
CASE STUDY 2

What do you do?
Focus on the patient and be ready to listen
Eliminate distractions
Sit at eye level
Ask if the patient would like loved ones to be present
Establish trust: recognize and validate the patient’s emotions
Avoid vague and technical terminology
Provide context
- Describe procedures involved in normal anesthetic course
- Provide risks and alternatives to anesthesia
Ask patient to state his/her goals for surgery and for end-of-life
Closing the conversation
- Offer a professional recommendation based on patient condition and priorities
- Clarify the difference between withholding CPR and withholding treatment

Landmark qualitative study of 18 terminally ill patients, interviewed between March 1994 – November 1995

Main themes:
1. Avoiding financial and emotional costs for themselves and their families
2. Being ready to die
Regarding resuscitation: “I don’t see any sense to it. It prolongs pain, not only to the family, but to everybody around you. And at the end, you have nothing anyway. It is not going to cure you and it is going to cost a fortune, so you might as well say, ‘once it’s done, it’s done.’”
Theme 2: Readiness to Die

“In my family, we do not believe in machines keeping you alive and we have been through this before and we don’t like the idea of machines. When it is your time to die, it’s your time to die.”

“I have come to a point in my life where I (pause) ... it’s not giving up the fight so much as letting things go to a logical progression within a reasonable time frame”
Anesthesia Is Different

“Well, in the operating room, that to me is like hallowed ground. Whatever goes on in the operating room is something special. You have someone special working on you. You have your anesthesiologist, and, from what I’ve heard of operating rooms, is that the patient goes to sleep and wakes up in the recovery room ... the anesthesiologist can’t just say, if you stop breathing or something, ‘That’s it. He’s gone.’ ... In the operating room, I would say, ‘Yes, I want a suspended order.’ I want the doctor to do the best he can.”

“The operating room has got to keep you going ... because you are under anesthesia and you are entirely different than when you are not.”
Patient and doctor attitudes and beliefs concerning perioperative do not resuscitate orders: anesthesiologists’ growing compliance with patient autonomy and self determination guidelines

Christopher M. Burkle¹, Keith M Swetz², Matthew H Armstrong¹ and Mark T Keegan¹
### Table 1 Patient responses to a series of general statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative DNR requests should be suspended for surgical procedures</td>
<td>131 (32%)</td>
<td>104 (25%)</td>
<td>62 (15%)</td>
</tr>
<tr>
<td>Requests not to be resuscitated should always be discussed between patient and surgeon or anesthesiologist</td>
<td>309 (74%)</td>
<td>74 (18%)</td>
<td>17 (4%)</td>
</tr>
<tr>
<td>Decisions about intraoperative resuscitation should be left up to surgeons and anesthesiologists alone because patients cannot fully understand the complexities involved with a surgical process</td>
<td>87 (21%)</td>
<td>94 (23%)</td>
<td>28 (7%)</td>
</tr>
<tr>
<td>The type of surgical procedure should influence whether a patient’s request not to be resuscitated is followed</td>
<td>113 (28%)</td>
<td>115 (28%)</td>
<td>61 (15%)</td>
</tr>
<tr>
<td>If a patient’s request to forgo resuscitation is suspended for a surgical procedure, it should be reinstated at a predetermined point following anesthesia recovery</td>
<td>206 (50%)</td>
<td>120 (29%)</td>
<td>50 (12%)</td>
</tr>
</tbody>
</table>
Table 3: Doctor responses to a series of general statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since anesthesia for surgery basically represents a resuscitative effort (endotracheal intubation, pressor support, etc.), DNR (“Do not Resuscitate”) status makes no logical sense in the context of a surgical procedure requiring an anesthetic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>87 (23%)</td>
<td>123 (32%)</td>
<td>26 (7%)</td>
</tr>
<tr>
<td>The delivery of every anesthetic likely involves depression and manipulation of the cardiac and respiratory systems and the anesthesia team must be permitted to use all their skills to provide the best possible anesthetic outcome for the patient regardless of preoperative DNR status.</td>
<td>124 (32%)</td>
<td>145 (38%)</td>
<td>30 (8%)</td>
</tr>
<tr>
<td>Since patients do not have the knowledge to adequately appreciate the idiosyncrasies involved in the practice of medicine, physicians should independently evaluate what is in the best interest of patients regardless of the contents of an advance directive with regard to perioperative DNR status.</td>
<td>15 (4%)</td>
<td>38 (10%)</td>
<td>37 (10%)</td>
</tr>
<tr>
<td><strong>DNR status should be respected during the intraoperative</strong> (while under the care of the anesthesia team to include the post anesthesia care unit) course because resuscitative issues are not the private preserve of health care providers but rather based on the patient’s own value system.</td>
<td>76 (20%)</td>
<td>113 (30%)</td>
<td>69 (18%)</td>
</tr>
<tr>
<td>DNR status should be disregarded during the perioperative phase of patient care because there is increased likelihood of successful resuscitation, regardless of the precipitating event, in the highly monitored setting of the operating room.</td>
<td>25 (7%)</td>
<td>96 (25%)</td>
<td>78 (20%)</td>
</tr>
<tr>
<td>Since it is difficult to distinguish between cardiopulmonary arrest that may occur spontaneously and that which occurs due to therapeutic intervention under anesthesia, DNR status should be disregarded during a patient’s perioperative course.</td>
<td>37 (10%)</td>
<td>126 (33%)</td>
<td>59 (15%)</td>
</tr>
<tr>
<td><strong>If the patient has sufficient capacity to consent</strong> to the risks and benefits intrinsic to surgery and anesthesia, they have sufficient capacity to refuse or agree to attempts at resuscitation resulting from an intraoperative cardiopulmonary arrest.</td>
<td>130 (34%)</td>
<td>162 (42%)</td>
<td>40 (10%)</td>
</tr>
</tbody>
</table>
DNR patients are individuals with different wants, needs and goals, and may present for various surgical procedures.

Approximately 25% of DNR patients that go to the OR die within 30 days of surgery.

However, all patients have the right of autonomy. Respect the patient’s decision!

DNR orders should NOT be automatically suspended for patients going to the OR.

Practice having a difficult conversation, and involve the entire perioperative team.

Understand the process at your institution.
QUESTIONS?

References


References


