Ethical Concerns in Anesthetic Care for Patients with Do-not-resuscitate Orders

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IN the past 5 yr, many articles*† have been published on the topic of surgical patients who have do-not-resuscitate (DNR) orders. Some recommend negotiated reconsideration with the patient (or surrogate‡) before anesthesia. ‡ The argument for this recommendation is based on the principle of respect for patient autonomy. Others recommend automatic suspension of DNR orders in the perioperative period.§‡

Three arguments are given to support suspension of DNR orders during surgery. First, consent for surgery and anesthesia implies consent at least for those resuscitative measures intrinsic to the administration of an anesthetic and is, therefore, inconsistent with a DNR order. Second, results of resuscitation in the operating room (OR) are better than resuscitation outside the OR; therefore, the usual considerations regarding DNR orders should not automatically apply to the patient having a surgical procedure. Finally, anesthetics cause cardiovascular and respiratory instability. Deprived of the ability to reverse these physiologic changes, the anesthesiologist may favor less anesthesia and greater physiologic stability, thereby depriving the patient of the full benefits of anesthesia, especially sufficient analgesia and amnesia.

Part, but not all, of the disagreement is related to interpretation of the term “resuscitation.” According to some, resuscitation during anesthesia refers only to closed chest cardiac compression and electrical countershock. § To others, it means any procedure used in resuscitation, including tracheal intubation, assisted ventilation, or the use of vasoactive drugs, or procedures that are also part of routine anesthetics.

The American Society of Anesthesiologists (ASA) has issued ethical guidelines (fig. 1) for the anesthesia care of DNR patients that recommend negotiated reconsideration of the DNR order and access to the patient’s wishes. The guidelines appear to use the broader definition of resuscitation.

This article describes one institution’s policy on DNR orders in the OR, and critiques the ASA guidelines.

Policy on Do-not-resuscitate Orders in the Operating Room at Scott & White Hospital and Clinic

At Scott & White Clinic and Memorial Hospital in Temple, Texas, our policy is a compromise between the extremes of automatic suspension of DNR orders and complete autonomy of the patient. Consequently, it is subject to criticism from both sides.

Our policy requires discussion of each patient’s DNR status between an anesthesiologist and the patient. This discussion occurs while obtaining informed consent for anesthesia. The anesthesiologist offers the patient two choices described on a clarification form (fig. 2). One choice is to maintain the DNR order, with the understanding that “clinical events thought to be temporary and readily reversible will be treated and that standard anesthesia procedures will be used.” This intentional vagueness allows the anesthesiologist to practice unhindered by restrictions more appropriate for non-OR settings, where life-supporting procedures are not commonplace. It may be reasonable for a patient outside of the surgical suite to refuse tracheal intubation, mechanical ventilation, oxygen therapy, or vasopressors; refusing these interventions in the OR may not be reasonable, particularly when they are integral parts of the

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† Kang WH: Putting people to sleep: Do not resuscitate orders in the operating room. JD Thesis. 1992 (personal communications).

‡ In this paper, whenever “patient” is referred to, that term will include “surrogate” if the patient is not competent or autonomous.

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ETHICAL GUIDELINES FOR THE ANESTHESIA CARE OF PATIENTS WITH DO-NOT-RESUSCITATE ORDERS OR OTHER DIRECTIVES THAT LIMIT TREATMENT

(Applied by House of Delegates on October 11, 1993)

These guidelines apply to conscious patients and to unconscious patients who have previously expressed their preferences.

I. Given the diversity of published opinions and values within our society, an essential element of patient-centered care includes patient preferences in the patient's consent for DNR orders. DNR orders or another directive that limits treatment is a communication among involved parties. It is necessary to document relevant aspects of this communication.

II. Patients autonomously request DNR orders or other directives that limit treatment prior to hospitalization involving anesthesia care may not sufficiently address a patient's right to self-determination in a responsible and ethical manner. Such policies, if they exist, should be reviewed and revised as necessary, to reflect the requirements of this guideline.

III. Prior to performing procedures requiring anesthesia care, any change or existing directives that limit treatment should be discussed in the medical records, including the patient's or the patient's legal representative.

IV. When appropriate, the items that should be considered include:

A. Blood pressure
B. Tracheal obturation or intubation
C. Cardiac rhythm or direct cardiac massage
D. Defibrillation
E. Cardiac pacing, internal or external
F. Ventilatory support
G. Pulsatile venous return
H. Vasoactive drug administration

V. Additional issues that may be relevant to discuss are perioperative placement of noninvasive vital signs or output catheters, administration of anesthetic agents, maintenance of intravascular volume with non-pulsatile venous return, and maintenance of intravascular volume with non-pulsatile venous return.

VI. It is important to discuss and document whether there are to be any exceptions to the injunctive measures included in the directive regarding complications of the surgery or anesthesia.

VII. Consequences of this issue for the primary physician, the surgeon(s), the anesthesia provider, and the patient and his or her family may be discussed with the patient and the patient's legal representative when these issues are discussed. This duty of the physician's diagnosis is deemed to be of such importance that it should not be delegated. Other members of the health-care team who are involved in the care of the patient during the planned procedure should, if feasible, be included in this process.

VIII. Should conflicts arise, the following resolution procedures are recommended:

A. When an anesthesiologist finds the patient's or the patient's legal representative's estimate of intervention directions to be incompatible with the patient's own moral views, then the anesthesiologist should withdraw as a nonparticipant, about the same time, and an anesthesiologist should choose or be chosen as an alternative for care in a timely fashion.

B. When an anesthesiologist finds the patient's or the patient's legal representative's estimate of intervention directions to be incompatible with the patient's own moral views, then the anesthesiologist should withdraw as a nonparticipant, about the same time, and an anesthesiologist should choose or be chosen as an alternative for care in a timely fashion.

IX. A representative from the hospital's anesthesiology service should establish a liaison with surgical and nursing staff for procedures, supervision of postoperative care, and maintenance of intravascular volume with non-pulsatile venous return. The health-care team should be made aware of the procedures of these discussions and the monitoring for them.

X. Modification of these guidelines may be appropriate when they conflict with local standards or policies, and in these emergency situations involving unconscious patients whose interests have not been previously expressed.

Fig. 1. American Society of Anesthesiologists Ethical Guidelines for the Anesthesia Care of Patients with Do-Not-Resuscitate Orders or Other Directives That Limit Treatment. Ethical Guidelines for the Anesthesia Care of Patients with Do-Not-Resuscitate Orders or Other Directives That Limit Treatment/1995 is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, Illinois 60068-2573.)

anesthetic management. Twenty senior staff anesthesiologists were unable to agree completely on what restrictions would be acceptable.

The other choice is to suspend the DNR order during the time the patient is in the OR and postanesthesia care unit. This is the default choice when surgery is considered emergent enough to proceed in the case of an incompetent patient whose surrogate is not available.

The process of completing the clarification form is intended to ensure that the patient and anesthesiologist discuss the patient’s overall goals regarding the surgical procedure rather than the use of specific interventions. A patient may refuse tracheal intubation when the real goal is not to be maintained on mechanical ventilation for a prolonged period. Whereas some authors recommend discussing the risks, complications, and alternatives for all possible therapeutic modalities and intraoperative interventions, we chose to focus on clarification of patients' goals. We believe this goals-oriented approach appropriately places responsibility with the physician to counsel patients regarding their condition and prognosis and to select techniques and therapies appropriate to attain the agreed-on goals.

Critique of the ASA’s Ethical Guidelines for the Anesthesia Care of Patients with Do-not-Resuscitate Orders or Other Directives that Limit Care

I have two major criticisms of the ASA's guidelines for the care of DNR patients in the OR: they are not feasible

Fig. 2. Scott & White Memorial Hospital clarification form for patients with do-not-resuscitate orders scheduled for anesthesia and surgical care.
in our practice and they appear to make respect for autonomy an absolute, rather than a \textit{prima facie}, principle. These arguments are based on my interpretation of the ASA guidelines and the discussion of the guidelines by Fine and Jackson.

\textbf{Feasibility}

Beauchamp and Childress\textsuperscript{12} state that the implementation of moral principles must take into consideration feasibility, efficiency, and cultural pluralism. In our practice, the physician who obtains consent for anesthesia is often not involved with the intra- and postoperative anesthetic management. Other duties of the anesthesiologists, schedule changes, and cases not finishing as scheduled make it impossible to guarantee the continuity of care necessary to completely implement the ASA guidelines. Knowledge of other practices leads me to believe our logistical problems are not unique.

Our anesthesiologists' attitudes range from those who would not treat hypotension or dysrhythmias caused by induction of anesthesia, if that were the patient's wish, to those who would not administer an anesthetic without being able to treat easily correctable iatrogenic problems. All agree with the general concept of DNR orders. The disagreement is in the interpretation of what constitutes resuscitation and exactly where the line is drawn in a given clinical situation. Resuscitation may refer only to closed chest cardiac compression and electrical countershock, or it may include treatment of problems leading up to a cardiac arrest and even the treatment of drug-induced respiratory arrest. Without the compromise, we could never have reached an agreement that would allow one person to negotiate with a patient and make a commitment for one or more associates involved in the intra- and postoperative anesthetic care.

Ideally, the negotiation with the patient would involve the entire operating team; once again, an ideal that is not feasible. For logistical reasons, it was agreed that the clarification form would be completed by an anesthesiologist while obtaining consent for anesthesia. This seemed logical because we are often the cause of intraoperative "clinical events," and we are always the primary resuscitators.

Physicians are moral agents with autonomy. The ASA guidelines recognize this and allow for physicians to withdraw from unacceptable situations. During nights and weekends, our anesthesiologist on call is expected to provide anesthesia care for all presenting patients. Each anesthesiologist has a unique combination of strengths and weaknesses, preferences and dislikes, and levels of comfort for given situations. By focusing our discussions on goals, rather than specific interventions, we have kept such unacceptable situations to a minimum.

Therefore, we have adopted a policy that is a modification of the ASA guidelines (section X of the ASA guidelines), a compromise that is feasible and superior to our previous policy of automatic suspension of DNR orders in the OR.

\textbf{Patient Autonomy}

In their discussion of the ASA guidelines, Fine and Jackson state: "The premier and fundamental principle of bioethics is that of respect for the \textit{autonomous choice} of the patient" (p. 46). Although they mention nonmaleficence and beneficence and admit that anesthesiologists are also moral agents, they appear to consider respect for autonomy as an absolute, rather than a \textit{prima facie}, principle. \textit{Prima facie} principles are obligations to be followed unless they are in conflict with an equal or stronger obligation. An absolute principle — there can be only one — takes precedence over any other principle or rule when principles or rules conflict. Beauchamp and Childress,\textsuperscript{12} who developed the "four principle" theory of bioethics (autonomy, nonmaleficence, beneficence, and justice), reject not only absolute principles, but also any hierarchical or lexical ordering of the principles.

Several problems exist with making respect for patient autonomy the premier and fundamental principle of bioethics, particularly in the practice of anesthesiology, and Fine and Jackson allude to some of them.

First, autonomy (self rule) is limited by our relationships with others: autonomy is never absolute.

Second, the patient is not the only moral agent involved. In addition to the patient are the members of the anesthesiology team, the surgical team, and postanesthesia care unit personnel. All moral agents have duties and rights. The perioperative period is not a situation where the patient is the only agent with rights. Whereas only patients can determine their ultimate goals, they must often trust their caregivers to help them achieve those goals.

Third, patients in the OR are rarely autonomous; usually they are under the influence of drugs that render them incapable of acting intentionally and with understanding.
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is expected of OR patients. The care of OR patients is more complex and involves issues that are not unique to the operating room environment. The authors state that decision making is a complex process and that the ASA guidelines are not intended to apply to our specific setting.

A DNR order is a modification of the standard medical order system. The authors state that DNR orders are intended to be a specific type of medical order that is used to indicate the patient's preference not to receive CPR in the event of cardiac arrest. The guidelines provide specific instructions for the documentation of DNR orders in the medical record.

The authors also discuss the potential for DNR orders to conflict with other medical orders and the importance of clear communication between the medical team and the patient or family. They emphasize the need for clear communication to ensure that all parties understand the patient's wishes and that the DNR order is appropriately documented.

The authors conclude by thanking the patient and family for their involvement in the decision-making process and for allowing them to participate in providing their care.

References