

## PATIENT AUTONOMY

# *Is It Ethical to Suspend A DNR Order in Surgery?*

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**E**ver since cardiopulmonary resuscitation (CPR) was developed in the mid-20th century, it has held a unique place in American medicine as the single major medical intervention for which consent is presumed rather than required.

That presumption is strongly embedded in the culture of American medicine. Only the request of a patient can overturn it, and only if the request is confirmed by a “Do Not Resuscitate” (DNR) order from a licensed independent provider. In those cases, the patient, or his or her surrogate decision-maker, has taken the proper steps to notify the treatment team that it no longer has permission to attempt resuscitation.

However, the strength of the presumption in favor of CPR occasionally has led medical staff to determine that a DNR order should be ignored — that is, “suspended” — in certain circumstances, without additional conversation with the patient or surrogate. This tendency has been particularly prevalent in the operating room, where the practice of suspending DNR orders is not uncommon.

### POSITION STATEMENTS

Statements by the American Society of Anesthesiologists,<sup>1</sup> the American College of Surgeons,<sup>2</sup> the American Association of Nurse Anesthetists,<sup>3</sup> and the Association of periOperative Registered Nurses<sup>4</sup> agree that the unilateral discontinuation or suspension of DNR orders in the perioperative setting — that is, the time period encompassing a patient’s preparation for surgery, the surgical procedure and post-operative recovery from anesthesia — is inconsistent with the Patient Self-

Determination Act of 1992 and a patient-centered ethic of respect for patient autonomy.

The *Ethical and Religious Directives for Catholic Health Care Services*, specifically directives 26 and 27, say a patient or surrogate must give “free

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and informed consent” for medical treatments and procedures, “except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment.”<sup>5</sup>

Thus, unilaterally suspending DNR orders in the operating room is inconsistent with Catholic health care’s collective value of respect for the person and the principle of autonomy, as well as being detrimental to a culture of patient-centered care. But if the “suspension” practice is to end, a system or medical center must ensure that three elements are in place to support such a change in practice:

■ The facility has a “required review” policy. DNR orders cannot be unilaterally discontin-

ued in the perioperative setting. Training must explain the ethical rationale and the requirement for detailed conversations with patients or their surrogates before surgery.

- Staff must understand clearly the legal nuances of DNR orders and their implications

- The policy gives providers who have ethically sound reasons the option to recuse themselves from participation in a patient's DNR order

### ETHICAL RATIONALE

Here is a hypothetical case that shows how complicated and confusing DNR circumstances can get:

Mr. Jones is a 65-year-old patient who has end-stage kidney disease. Two weeks ago, his doctor told him he had about six months left to live and invited him to discuss his options for that period of time. Mr. Jones decided he was willing to continue his biweekly dialysis treatments, but he did not want to escalate care and he didn't want to go to the hospital. Mr. Jones made preliminary

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arrangements for hospice care and signed an out-of-hospital DNR order.

Outside his dialysis center the following week, Mr. Jones was struck by a bus. The bus driver immediately began CPR, but when the ambulance arrived, the EMS squad saw Mr. Jones' authorized DNR bracelet and interrupted the bus driver's efforts. The bus driver objected, concerned about a manslaughter charge, and he argued that they should make every effort to resuscitate Mr. Jones.

"For God's sake," the driver shouted, pointing to the dialysis center ID Mr. Jones was still wearing, "the man just walked out of a dialysis center. He obviously still wanted treatment!"

Though they understood the bus driver's distress, the EMS crew explained that the DNR bracelet meant Mr. Jones had withdrawn consent

to attempt resuscitation.

Embedded in this case study are a number of issues that many operating room personnel would find familiar. The bus driver's first reaction is to draw a distinction between the patient's underlying disease (which the DNR order suggested he expected to die from) and the immediate cause of his cardiac or respiratory arrest — being hit by a bus.

In a similar manner, anesthesiologists have argued that the principle of non-maleficence (do no harm) should be the overriding factor if anesthesia, not the patient's underlying disease, directly causes a patient to stop breathing or for his or her heart to stop.<sup>6</sup> This is a valid concern and represents a true ethical dilemma: Which principle or value should be given greater weight in such a situation?

This dilemma reinforces the need — before surgery — for a detailed conversation between the relevant providers and the patient (or surrogate) to discuss his or her wishes if there were a life-threatening turn of events in the operating room. Otherwise, just as the bus driver did, members of the operating room staff may argue in all good conscience that the DNR can and should be unilaterally suspended because the patient wouldn't have sought surgery in the first place if he or she did not wish to prolong his or her life.

That's not always true. A 1995 study demonstrated that 15 percent of patients with an existing DNR order do undergo surgical procedures, most often with a palliative focus.<sup>7</sup> Yet as our story about Mr. Jones illustrates, a willingness to engage in one form of treatment does not mean that there is a corresponding willingness to engage in a more invasive procedure. There could be any number of reasons a patient might agree to further treatment, even surgery, but be unwilling to have resuscitative efforts attempted. And a patient would have no reason to think his or her DNR order could be overruled in the operating room.

While OR personnel may feel that a DNR order could be unilaterally suspended in the perioperative setting, particularly when they may feel "that it was their actions that led to the death of the patient," the critical factor remains the right of the person to refuse an unwanted medical procedure.<sup>8</sup>

To restate: Once a person has exercised the right to effectively reverse the presumption of consent to CPR or other lifesaving measures, then



respect for the person, a commitment to patient autonomy and a desire to form a patient-centered culture make an additional conversation with the patient ethically mandatory when a patient with a DNR order presents himself or herself for surgery.

#### **POLICY AND PROCEDURE**

An appropriate medical center policy would state that a previously written DNR order remains in effect in the operating room or during a procedure unless clearly addressed beforehand. When a patient with a DNR order is scheduled for a procedure, a physician involved with the procedure must discuss with the patient or his or her surrogate decision-maker the possibility and implications of discontinuing the DNR order.

It is the responsibility of the patient or surrogate to consider the risks, benefits and alternatives of the procedure, including the possibility of intraoperative cardiac or respiratory arrest (to be clearly distinguished from pre-arrest complications and related interventions) and, under those circumstances, whether or not the patient wishes to have the DNR order revoked. The physician must put in the medical record both the discussion and any change in orders.

As a general rule, a previously recorded DNR order cannot ethically be suspended or unilaterally discontinued by a physician. Respect for the dignity of the human person, the principles of informed consent and patient autonomy require that the patient's preferences be honored.

#### **UNDERSTANDING THE DNR ORDER**

A DNR order is a medical order by a licensed independent provider that resuscitative efforts should not be initiated *in the unique event of* cardiac or pulmonary arrest. A DNR order is written according to precise legal wording, and training will help staff differentiate between resuscitative efforts and pre-arrest interventions.

Fortunately, most states have very similar wording related to DNR orders. While most clinicians are familiar with the concept that "Do Not Resuscitate does not equal Do Not Treat," few clinicians have a clear understanding of the implications of this principle.

Here is another hypothetical situation to help illustrate:

Mrs. Smith is in the hospital. She is a 75-year-old woman with a DNR order who begins to experience severe difficulty breathing in the middle of the night, reflected in a reading of the oxygen levels of her blood dropping from the 90s to the 60s.

In the absence of any other information, should she be intubated?

It is easy to see why there might be some confusion around this issue. Sometimes we use a DNR order as the capstone to a comfort-care approach; sometimes we use a DNR order to draw a line in the sand, promising the family that we will continue to treat the patient aggressively, but only up until the point of cardiac arrest.

From a strictly legal perspective, the answer is simple. In the absence of any other orders, the

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patient should be intubated, because she has not experienced *the unique event of cardiac or pulmonary arrest*. The DNR order becomes operative in the most immediate sense only when this “trigger” has been met. So, while some of the same tools (such as the ventilator) might be used in various situations, they are considered truly resuscitative only when the patient has experienced cardiac or respiratory arrest.

It is worth noting that the Physician Orders for Life-Sustaining Treatments (POLST) form, which has become popular in many states, clearly makes this differentiation. One set of orders (code status) is followed if the patient does not have a heartbeat or discernible breathing. The second order set (treatment limitations) is followed if the patient *does* have a heartbeat or discernible breathing.

Making this important distinction clear is critical to helping clinicians understand the very limited scope of the DNR order. It is equally important that providers be able to explain these variations to patients pre-operatively in order to assure truly informed consent.

A clear understanding will reassure that anesthesiologist that a sudden drop in blood pressure can be addressed without violating the DNR order, and that intubating the patient as a part of the procedure is both allowable and appropriate.

Similarly, the patient needs to understand that his or her existing DNR order does not preclude the possibility of intubation (either in a planned

fashion or emergently prior to arrest). Only a clear and honest conversation between provider and patient can ensure a mutual understanding of the possible outcomes, while honoring the rights of the patient and the clinician’s commitment to autonomy and patient-centered care.

### **SUGGESTED POLICY AND PROCEDURE**

Medical center policy should clearly distinguish between pre-arrest orders, which may include treatment limitations such as “Do Not Intubate” or “Avoid admission or transfer to Intensive Care Unit for escalation of care” and post-arrest orders, which include only the options to Attempt Resuscitation (Full Code) or Do Not Attempt Resuscitation (No Code).

Note that a POLST form clearly makes this distinction, consistent with state law.

Remember that the code status order becomes operative in the most immediate sense only when the patient is in cardiac or pulmonary arrest.

Orders limiting treatment prior to arrest should be clearly indicated.

Affirming that “Do Not Resuscitate” does not mean or imply “Do Not Treat,” it is critical for staff to understand that all treatments and interventions are available to a patient with a DNR order until the point of cardiac or respiratory arrest. For example, it is possible for a patient with a DNR order to be intubated or to remain intubated.

It is important to explore with the patient or surrogate decision-maker whether to enter additional orders that place limits on the extent of life-sustaining measures to be employed in his or her care.

### **OPTION FOR RECUSAL**

Even with a clear articulation of the ethical rationale for not suspending a DNR in a perioperative setting, and armed with a more complete understanding of the DNR order itself and the limited circumstances in which it would become truly operational, situations will emerge in which a provider might find it ethically unacceptable to attempt surgery with a DNR order in place.

To allow for such cases, and to increase the likelihood that providers are true partners in this initiative, it is critical to fully support them — particularly anesthesiologists — if they choose not to participate in a particular procedure because they have a fundamental medical or ethical objection to doing so.

The hypothetical example:

Ms. Johnson is a 46-year-old female with a history of significant mental illness and multiple hospitalizations following suicide attempts. She retains decision-making capacity. She has developed coronary artery disease, which has worsened, primarily due to inconsistent compliance in her pharmaceutical treatment regimen. A Coronary Artery Bypass Graft (CABG) now seems like the best option, but the patient refuses to undergo the procedure without a DNR order in place, stating that if her heart were not to restart on its own, she wishes to be allowed to die.

This case involves a procedure during which the heart is intentionally stopped in order for surgery to be performed. While the heart usually starts beating on its own following restoration of blood flow, it may require interventions that are resuscitative in nature to help it restart. Because of this possibility, it would be perfectly reasonable for a provider to refuse to participate in such a surgery if the patient were not willing to have her DNR order temporarily discontinued. The provider also might note a fear that she or he was being asked to participate in a variation of physician-assisted suicide, given the patient's mental history and the unusual nature of the request.

Respect for the dignity of the human person, the principles of informed consent and patient autonomy require that we honor the resuscitation preferences expressed by the patient in such circumstances. A previously recorded DNR order cannot be suspended or unilaterally discontinued by a licensed independent provider.

However, neither is the provider required to participate in a course of action that would violate his or her ethical or religious beliefs. In such a case, the provider may choose, in a nonjudgmental fashion, to withdraw from the case.

#### IN SUMMARY

Given that the practice of suspending DNR orders in the operating room often has been viewed as acceptable, efforts to change this mindset depend on strong leadership and a willingness to engage a variety of stakeholders in thoughtful conversation.

The Catechism of the Catholic Church reminds us that "God created man a rational being, conferring on him the dignity of a person who can initiate and control his own actions. Freedom is the

power ... to perform deliberate actions on one's own responsibility."

This fundamental belief provides the theological foundation for patient-centered care. We have an opportunity to ensure that this shared value is honored everywhere, every time.

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#### NOTES

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