Reconsidering Do-Not-Resuscitate Orders in the Perioperative Setting

Susan M. Byrne, MSN, BSN, RN, Svetlana Mulcahy, MSN, RN, FNP-BC, Myra Torres, MSN, BSN, RN, Anita Catlin, DNSc, FNP, FAAN

Many of our elderly have now signed advance directives or physicians' order sets of life-sustaining treatment forms. Frequently, choices have been made for no life-sustaining interventions at the end of life or do-not-resuscitate (DNR) orders. As the proportion of elderly grows and more patients seek surgical intervention for comfort or to improve their quality of life, the medical and ethical issues of DNR orders in the perioperative setting become increasingly more complex. Many health care providers neither recognize the complexity and significance of the DNR order during the perioperative period nor have hospitals established actions toward resolution of this situation. This article will discuss how this complex issue should be explored, definitions established, and positions recommended.

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***MRS. SMITH IS A NON-VOCAL**, confused, but ambulatory 93-year-old female living in a Senior Group Home. Her Durable Power of Attorney for Healthcare indicates Do-Not-Resuscitate (DNR) status. While ambulating to the dining room one morning, Mrs. Smith falls. She is taken to the nearest community hospital emergency room where it is determined that she has incurred an intracapsular fracture of her left femur. A hospitalist and an orthopaedic surgeon evaluate the patient and feel that the most appropriate treatment is surgical pinning. They contact the patient's son, who lives out of state, to discuss their recommendations. After receiving the son's consent, the decision is made to proceed with surgery. In this hospital, the DNR status is routinely rescinded for surgical procedures and the son is notified of this. The patient remains clinically stable during the surgery; however, approximately 1 hour after arrival to the postanesthesia care unit (PACU), her condition begins to deteriorate. Initial efforts with administration of reversal agents and manual hyperventilation are not successful. The patient becomes bradycardic and resuscitation drugs are administered. Despite these efforts, the patient becomes asystolic and cardiopulmonary resuscitation is initiated. Cardiac compressions are started. She is intubated and a central line is inserted. During the compressions, the nurse feels rib bones breaking. The patient is resuscitated and transferred to the Intensive Care Unit. Some members of the postanesthesia nursing care team are visibly upset, but the schedule is tight and they must quickly return to caring for the other patients in the PACU. Early the next day, after discussions with the son, the patient is transitioned to*

Susan M. Byrne, MSN, BSN, RN, Director Quality and Accreditation, Co-chair Ethics Committee, Kaiser Permanente Medical Center San Rafael, San Rafael, CA; Svetlana Mulcahy, MSN, RN, FNP-BC, Family Nurse Practitioner, Mendocino Cast Clinics, Fort Bragg, CA; Myra Torres, MSN, BSN, RN, Nurse Clinician, CV Progressive Care Unit, John Muir Hospital, Concord, CA, and Faculty, Oblone College of Nursing, Neward, CA; and Anita Catlin, DNSc, FNP, FAAN, Director of Research and Redesign, Co-Chair Ethics Committee, Kaiser Santa Rosa, Kaiser Vallejo Research Council, Vallejo, CA.

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Address correspondence to Susan M. Byrne, Kaiser Permanente Medical Center San Rafael, 99 Monticello Road, San Rafael, CA 94903; e-mail address: suzie.byrne@kp.org.

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comfort care status, lines pulled, and she is extubated. While changing the patient's gown, the ICU nurse caring for the patient is tearful as she notes her bruised and disproportionate chest. The nurse administers a subcutaneous injection for the potential pain the patient may feel. Mrs. Smith dies a few hours later.

Background

The National Institute on Aging projects that one in five Americans will be aged 65 or older by the year 2030. The fastest growing sector of the elderly population is the subgroup aged older than 85 years.[1] Surgery will be increasingly common in this growing elderly population.[2] Patients with terminal and end-stage disease are also living longer. Many patients who have chosen palliative care may desire surgical or procedural intervention. These interventions in patients near the end of life are designed to relieve distress, improve function, and possibly enhance survival.[3] According to the Association of Perioperative Registered Nurses (AORN), it is estimated that 15% of patients with do-not-resuscitate (DNR) orders still choose to undergo a surgical procedure.[4] For many hospitals and health care providers, the complex medical and ethical issues of DNR orders in the perioperative setting, although not new issues, remain unrecognized and unresolved. Often policies are outdated or unclear, leaving the staff unsure or misguided about what to do. This article will provide hospital policy writers and care providers with guidelines to assist them in establishing clear hospital policies that are both procedure and patient centered.

Understanding DNR Orders in the Perioperative Setting

In an effort to determine the best position to take on DNR orders in the perioperative setting, the following medical and ethical issues must be addressed:

- What positions do professional health care organizations take on these issues?
- What defines the operative or perioperative setting or period?
- What does resuscitation mean in the perioperative setting, and to what extent is it used in the context of code status or end-of-life directives?
- What are the ethical considerations involved in these issues?
- What are the interests and requirements for individuals of the health care team?
- How should the evidence be applied?

What Positions Do Professional Health Care Organizations Take on This Issue?

Many professional health care organizations have guidelines or position statements on the issue of DNR in the perioperative setting. Unfortunately, many health care providers remain unaware of their own professional policies, and facility positions and practices do not always align with existing professional policies.

The American Society of PeriAnesthesia Nurses (ASPAN) Position Statement on the Perianesthesia Patient with a Do-Not-Resuscitate Advance Directive recommends reclarification of the patient's wishes before receiving anesthetic medication. The position statement endorses informed consent discussions including a thorough review of the patient's directives, which are then carefully documented. ASPAN prescribes established policies for the management of a patient's DNR status during the perianesthesia period. The statement further advocates the rights of the perianesthesia registered nurse (RN) to object to participate in a patient care situation, as long as the care needs of the patient are met.[5]

The AORN Position Statement on Perioperative Care of Patients with Do-Not-Resuscitate or Allow-Natural-Death Orders specifies that the perioperative nurse, as the patient's advocate, has an ethical and moral responsibility to the patient. The position statement proposes that an automatic suspension of a DNR order during surgery undermines a patient's rights, reconsideration of DNR is required, and discussion should occur before the surgery or procedure and should be documented and communicated. The AORN statement asserts that if the perioperative nurse has a moral objection to the patient's decision, then he or she will be allowed to find another perioperative RN to provide care.[4]

The American Association of Nurse Anesthetists policy regarding Advanced Directives states that