

*For the complete text of the  
ASA Clinical Guidelines for Peri-Operative DNR  
Orders Revised 2013 [click here](#)*

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## **Perioperative Do-Not-Resuscitate Orders**

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*Vex not his ghost. O, let him pass. He hates him that would upon the rack of this tough world stretch him out longer.*

– The Earl of Kent comments on the king's death in *The Tragedy of King Lear*

*An 83-year-old man with metastatic prostate cancer develops a small bowel obstruction. He has an active DNR order but consents to the surgery with no further discussion about his DNR status. Shortly after being brought to the operating room and undergoing general anesthesia, he develops ventricular tachycardia. Chest compressions are started and after multiple epinephrine boluses and asynchronous cardioversion, the patient regains a perfusing sinus rhythm. The anesthesiologist starts an epinephrine infusion while the surgeon leaves to consult with the patient's family who, wanting to honor the patient's wishes expressed in his DNR order, requests the epinephrine infusion be discontinued with no further attempts at resuscitation. The anesthesiologist agrees and, after the epinephrine infusion has been stopped, the patient's blood pressure declines and the cardiac rhythm again degenerates to ventricular tachycardia. This time no CPR is performed and the patient expires in the operating room.*

Justice Cardozo, in the case of *Schloendorff v. Society of New York Hospital*, penned the classic statement that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body ...”<sup>1</sup> It is widely recognized that adults who have the capacity to make their own decisions also have the right to direct the course of their medical treatments, including the right to refuse treatment even when such refusal involves foregoing life-sustaining interventions. Competent patients, by law, can refuse automatic life-saving procedures as long as they fully understand the implications of their decision. Health care providers who attempt to resuscitate patients against their wishes violate their moral and legal right to self-determination. The do-not-resuscitate (DNR) order is the legal and medical document that reflects the patient's decision and desire to avoid life-sustaining interventions.

Anesthesiologists often encounter patients who have active DNR orders. Approximately 15 percent of patients with DNR orders are brought to the operating room for procedures that frequently are geared toward improving the patient's quality of life.<sup>2</sup> Although the presence of a DNR order for patients who undergo emergency surgery is an independent risk factor for poor surgical outcome and postoperative mortality,<sup>3,4</sup> the likelihood of returning patients to their prior level of function is higher for CPR performed during the perioperative period than at any other time.<sup>5</sup>

Part of the anesthesiologist's role in the operating room is to provide anesthesia sufficient to perform the surgical procedure and often requires resuscitative maneuvers such as endotracheal intubation, mechanical ventilation, and the use of fluids and drugs to support the cardiovascular system. **Most anesthesiologists find it untenable to be**

required to provide anesthesia to a patient yet be prohibited from resuscitating the patient from complications accompanying the delivery of anesthesia, or be required to clearly distinguish between needed resuscitation as the consequence of the anesthesia from needed resuscitation from any other process.

Three moral arguments support suspension of DNR orders during anesthesia and surgery.<sup>6,7</sup>

- First, patients who come to the operating room have consented to the surgical procedure and its attendant anesthesia because they hope the surgery will confer some desirable benefit. The anesthesiologist, however, cannot always separate out a needed resuscitation due to anesthesia from other processes that depress the cardiovascular system, so **the consent for anesthesia must also imply consent for resuscitation.**
- Second, cardiopulmonary arrests arising from therapeutic interventions are very different from cardiopulmonary arrests that occur in other settings. In the former instance, the arrest is likely to be reversible while, in the latter, CPR alone rarely reverses the primary problem.<sup>8</sup>
- Third, patients with active DNR orders undergoing anesthesia want the full benefit of anesthesia but anesthesiologists may feel compelled to deliver less-than-optimal anesthesia in order to maintain hemodynamic stability and reduce the possibility the patient may require “forbidden” resuscitation. Therefore, **even in the absence of a document suspending the DNR order, there may be implied consent to resuscitation by patients who have consented to surgery and anesthesia.**

The current ASA Ethical Guidelines for the Anesthesia Care of Patients with Do-Not-Resuscitate Orders or Other Directives that Limit Treatment<sup>9</sup> recommends a **preoperative discussion** for all patients with active DNR orders. The discussion should include the **patient and the anesthesiologist** as well as the patient’s primary physician and **surgeon**. **Other members of the patient’s health care team** should also be involved whenever possible. In the above scenario, there was no discussion among the family, the patient, the surgeon and the anesthesiologist about the limits of the DNR order during surgery. At a minimum, the preoperative discussion should include:

- A **review** of any existing DNR order that may limit the use of resuscitative procedures and clarification or modification of the DNR order;
- Any **exceptions to the DNR order** should there arise specific complications during the surgery or anesthesia; and
- **Explicit plans for reinstating the DNR order** when the patient has recovered from the acute effects of anesthesia.

If the patient asks the anesthesiologist to **use clinical judgment** to determine when a resuscitative procedure is appropriate, this request should be **documented** in the patient’s medical record in a manner that demonstrates how this request is consistent with the patient’s values and goals.

Usually one of the following three courses of action is chosen after the discussion:

1. A **full attempt** at resuscitation;

2. A limited attempt at resuscitation with regard to specific procedures; or
3. Limited attempts at resuscitation consistent with the patient's goals and values.

If full attempt at resuscitation is chosen, the DNR order is suspended in its entirety during the course of the anesthetic and immediate postoperative period. In our scenario, the surgeon and anesthesiologist initially treated the patient as if the DNR order had been suspended.

For limited attempts at resuscitation with regard to specific procedures, the patient may refuse certain resuscitative procedures such as endotracheal intubation, chest compressions, defibrillation or vasoactive drugs. In such instances, the anesthesiologist should tell the patient which procedures are necessary for the proposed surgery and which may be refused. In our scenario, after an initial resuscitation had taken place, the patient's family specifically asked that the vasoactive drugs be discontinued.

In the third instance, if the patient chooses a limited attempt at resuscitation as defined by the patient's goals and values, the patient permits the anesthesiologist and the surgeon to use clinical judgment to decide which resuscitative procedures may be appropriate in each given situation in a manner that is consistent with the patient's goals and values.

When the DNR order has been suspended for a surgical intervention, provisions should be made to reactivate the DNR order when conditions that justified suspending the DNR order are no longer present. A reasonable time to reactivate the DNR order may be at the time the patient's clinical condition has been deemed stable for discharge from the postoperative recovery room.<sup>10</sup> If the patient requires continued mechanical ventilation in the ICU, the intensive care physician may assume primary responsibility for deciding when conditions are suitable to reactivate the DNR order.

For anesthesiologists who believe caring for a patient with an active do-not-resuscitate order violates their conscience or impairs their professional judgment, it is ethically acceptable for them to refuse to deliver anesthesia to patients with active DNR orders, provided the patients or their surrogates are assisted in arranging for alternative care.

In emergency situations when there is insufficient time to ponder these issues without causing additional suffering, morbidity and possibly mortality, the anesthesiologist may proceed in a manner that is most consistent with the patient's goals and values as expressed by the patient or his or her surrogate.<sup>10</sup>

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