Knowing when to stop:
DNR in the OR

In too many hospitals, do-not-resuscitate (DNR) orders are automatically suspended when the patient passes through the OR doors, violating the individual’s right to make decisions and going against what every major association related to perioperative care recommends.

“This practice is short sighted and ill advised,” says Richard Cook, MD, associate professor, Department of Anesthesia and Critical Care at the University of Chicago.

Having a policy requiring a DNR order to be reviewed before surgery doesn’t guarantee it will happen.

“It’s a huge problem,” says David Waisel, MD, Department of Anesthesiology, Perioperative and Pain Medicine, Children’s Hospital, Boston. “The discussion is done poorly or not at all.”

This situation puts perioperative nurses in the hot seat when patients arrive in the OR with a suspended DNR and no documentation of a discussion with the patient.

How can you ensure patients’ rights are respected? Start by understanding this complicated issue and working to put a mechanism in place to define the process.

Why now?

In the early 1990s, clinicians began questioning the practice of suspending DNR orders in the OR. The American Association of Nurse Anesthetists (AANA), American College of Surgeons (ACS), Association of periOperative Registered Nurses (AORN), and American Society of Anesthesiologists (ASA) developed guidelines recommending “required reconsideration” for patients with a DNR order. Physicians were to discuss resuscitation in the OR with the patient or patient’s surrogate to determine whether the order should be suspended, retained, or revised.

Reaction to this well-intended concept has been lukewarm, even as more terminally ill patients undergo surgery. Such surgery includes procedures to alleviate pain and relieve intestinal obstruction in patients with advanced malignancy. Another factor contributing to difficulty in tackling this issue is that “we’re getting more aggressive about getting patients’ wishes stated on admission,” says Dr Cook. This trend can be traced back to the landmark Patient Self-Determination Act of 1990, which emphasized the patient’s right to autonomy, and to the requirement that facilities receiving Medicare and Medicaid payments ask patients about advance directives. More patients now have advance directives that include DNR requests.

Roadblocks to implementation

Clinicians claim to value patient autonomy, so why is it so hard to put required reconsideration in practice?

Experts attribute the difficulty to several barriers.

• **Belief that anesthesia is inconsistent with no resuscitation.** Many of anesthesia’s interventions, such as intubation, controlled ventilation, and administration of vaso pressors, are viewed as resuscitation in other settings.

• **Fear of lawsuits.** This can be summed up as, “What if the family changes their mind after the patient dies?” Dr Waisel says this fear is unwarranted. Few physicians have been sued for adhering to DNR orders, and none successfully. On the other hand, physicians and hospitals have been sued for resuscitating a patient with a DNR order.

• **Many OR cardiac arrests are easily reversed,** so clinicians don’t want to be
boxed in. Dr Waisel says that’s why it’s important to discuss the patient’s goals for resuscitation. For example, patients may have a DNR order but still prefer to be intubated for several hours if they will be able to return to their previous level of function.

- **Lack of experience** in holding these conversations with patients. Physicians may be uncomfortable in bringing up the topic, but in reality, Dr Waisel says, “These patients have already thought about it.”

- **Time pressures.** In the fast-paced world of surgery, who has time for lengthy discussions? “People think it takes too much time, but that’s not the case,” says Dr Waisel. “I do it often, and it usually takes about 5 to 10 minutes when you know how to do it.”

- **Unique environment of the OR.** “It’s a painful and difficult experience to have someone die in the OR,” says Dr Cook. Often surgeons and anesthesiologists feel they will be blamed for the patient’s death, and the staff look on it as a failure. Another difficulty is simply lack of focus. “It’s like anything else,” says Dr Waisel. “If the administration puts focus on it, it gets fixed.” He says administrators could ask for documentation that discussions have been held with each patient who has a DNR.

**Hot issue**

Association guidelines agree that physicians should be the ones to discuss DNR status with patients.

“We feel it’s [DNR] a physician-level area of responsibility,” says Byron Burlingame, RN, BSN, MS, CNOR, perioperative nursing specialist for AORN. ACS says the surgeon should take a “leadership role,” and the ASA says the primary physician (if not the surgeon), the surgeon, and the anesthesiologist should meet together with the patient.

In clinical practice, it can be next to impossible for 3 physicians to arrange a meeting. And the lack of consensus on who should initiate the discussion can make it a hot potato between the surgeon and anesthesiologist. “Most of the time, it’s whoever grabs the ball,” says Dr Waisel.

Dr Cook recommends that whoever talks with the patient should describe the potential for encountering resuscitation situations and the likelihood that resuscitation would be successful. Next, “ascertain if the patient wants to be resuscitated if there is a reasonable prospect that the condition that generated the need for resuscitation is temporary.”

**Be proactive**

The best way to ensure patients retain the right to make decisions is to be proactive. Ensure that patients or their surrogates understand their rights and have an unambiguous policy for the facility. If there is no policy, work with the appropriate surgical and anesthesia committees, risk manager, attorney, and ethics committee to formulate one (sidebar).

The Joint Commission requires organizations to have policies for advance directives, including the framework for forgoing or withdrawing life-sustaining treatment and withholding resuscitation. It also requires organizations to determine how a patient going to surgery with a DNR order will be managed.

A policy helps define the process but is no substitute for thoughtful discussion with the patient. Careful documentation of the discussion is crucial and should include the plan, who was involved in the conversation, and when the DNR is to be restored (if it is suspended). Some hospitals have specific forms that list the options discussed.

“A form is a wonderful way of getting the conversation started,” says Dr Waisel. “It helps people with finding the right words.”

Policies can’t be “one size fits all,” however.

“The situations that arise in the care of patients expected to die are different from those who prefer not to be resuscitated or who wish to avoid particular types of interventions,” says Dr Cook. “What’s most important is that the policy helps get
everyone on the same page about what to do in each individual situation.” For that reason, he cautions against using standard forms that can pigeonhole patients.

AORN doesn’t have a recommendation about how specific DNR orders need to be because legal requirements vary by state, says Burlingame.

Educate staff on the details of the policy, including a staff member’s right to seek a substitute assignment.

“Get someone from the ethics team to talk about DNR orders so the staff can clarify their thinking in this area.” Burlingame suggests.

It's important to have good communication from the time a case is scheduled. Burlingame suggests a checkbox on the scheduling form that addresses resuscitation status. The nurses in the OR and the anesthesiologists also need to communicate because one may learn about a DNR status before the other.

**What if someone disagrees?**

What happens if the surgeon, anesthesiologist, or OR staff disagree with a patient’s decision? There are 3 potential outcomes.

If the decision conflicts with someone’s moral views, that person needs to withdraw from the case. A nurse who disagrees with a patient’s DNR order should notify his or her supervisor so the assignment can be changed if possible.

Burlingame suggests that OR managers “ask staff members if they would be willing to participate in a surgery on a patient with a DNR order before the situation arises.” They will then have a list of nurses who are willing to participate.

If the decision conflicts with accepted standards of care, ethical practice, or policies, the dissenting party should express concerns to the appropriate facility contacts.

If these 2 alternatives aren’t feasible in the time frame, care should proceed according to the patient’s directives. For example, if another nurse isn’t available, the nurse has the moral duty to uphold the patient’s decision.

“The patient’s decision is the most powerful,” says Burlingame. “We as nurses need to put the patient’s wishes first, even when we don’t agree.” If there is time, the hospital’s ethics committee can help with the discussion.

**Giving patients control**

The bottom line is to ensure that patients are in control. “We’re talking about people controlling how they want to live,” says Dr Waisel. He uses a simple example for those struggling to have that conversation with the patient. “If this were your dad, what would you want?” Invariably, clinicians say, “I would want my dad to be able to decide what to do.”

Though physicians are responsible for the required-reconsideration discussion, OR managers “can often engage everyone in ways to help increase the quality of the discussion,” says Dr Cook. “They have a duty to the patients who come into the OR to ensure their rights are maintained throughout the surgical experience.”

—Cynthia Saver, RN, MS

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Elements of a perioperative DNR policy

Elements of a policy include:

- Statement that reevaluation is required before surgery
- Identification of who is responsible for reevaluation
- Available options. The American Society of Anesthesiologists defines these as:
  1. Full attempt at resuscitation. Full suspension of advance directives.
  2. Limited attempt at resuscitation defined with regard to specific procedures. Refusal of certain specific resuscitation procedures (for example, chest compressions, defibrillation, or tracheal intubation).
  3. Limited attempt at resuscitation defined with regard to the patient’s goals and values. The anesthesiologist and surgical team can use their clinical judgment in determining which resuscitation procedures are appropriate in the context of the situation and the patient’s stated goals and values. For example, a patient may want to be resuscitated if the condition could be easily reversed but not if it is likely to result in dependence on life-sustaining technology. Some criticize this approach, saying it places control in the physician’s hands, not the patient’s.
- Required documentation
- Time limitations (normally the DNR is reinstated when the patient leaves the OR).