**SESSION TITLE:** Do-Not-Resuscitate Orders in the Perioperative Environment: To Honor, Suspend, or Reconsider... That is the Question!

**SPEAKER NAME:** Mary A. Hillanbrand, DNP(c), MSN, RN, CNOR, Capt, USAF, NC  
Linda J. Wanzer, DNP, RN, CNOR, Col (Ret.) US Army

**SESSION NUMBER:** 9073 & 9131R

**DATE/TIME:** Thursday, March 7, 2013, 8-9am & 9:30-10:30am

**CONTACT HOURS:** 1.0 CH

**OVERVIEW:**
This presentation will explore current facility Do-Not-Resuscitate (DNR) policies while still respecting the wishes of the patient. As the patient advocate, it is our responsibility to ensure our patients are treated with respect and dignity throughout the course of their life and death. This presentation will highlight key elements that should be included in a perioperative DNR policy and aid the perioperative nurse, manager, and educator to understand that “Do Not Resuscitate” can best be achieved through end-of-life protocols and education that are supported and understood by patients, families, and by all within the health care team.

**OBJECTIVES**
1. Discuss the historical background of the Do-Not-Resuscitate (DNR) policy.
2. Identify ethical issues surrounding suspension of DNR orders in the perioperative arena.
3. Discuss current challenges regarding DNR policies in the perioperative environment.
4. Discuss implications for practice, research, education, and policy formation of DNR policy in the perioperative environment.

**BIOGRAPHIES:**
Mary A. Hillanbrand, DNP(c), MSN, RN, CNOR, Major, USAF, NC, is a perioperative nurse on active duty in the US Air Force who is currently assigned as an assistant professor in the Perioperative Clinical Nurse Specialist program at the Uniformed Services University in Bethesda, Maryland. In her current role, she is also the director of clinical education for the Perioperative Clinical Nurse Specialist Program responsible for coordination of clinical rotation sites on an international level. Mary has worked in the perioperative environment for over 30 years, which includes more than 12 years as a certified surgical technician. She has had multiple local and national presentations related to waste management and "greening" the OR, including a publication in the AORN Journal. Her field of interest is sterile processing, in particular, the development of educational interventions to increase compliance with recommended practice statements as they relate to cleaning and decontamination of surgical instrumentation. In support of that endeavor, she has developed CE activities related to cleaning and decontamination of surgical instrumentation, and is actively involved in identifying measures to improve patient outcomes related to the cleaning and reprocessing of surgical instrumentation. Additionally, Mary is involved with promoting certification for all perioperative team members, as well as advance practice nurses in the perioperative environment.
Linda J. Wanzer, DNP, RN, CNOR, Col (Ret.), holds the academic rank of assistant professor in the position of director for the perioperative clinical nurse specialist masters program at the Uniformed Services University of Health Sciences, Bethesda, Maryland. Prior to her retirement from the US Army after 28 years of service, she had the honor of being appointed, as a collateral duty, to be the Army Nurse Corps Perioperative Consultant to the Surgeon General. In this position, she was charged with the formulation of collaborative health care policies and strategic plans in an effort to impact the provision of patient care in the US Army while setting the path for the future of perioperative nursing in the military. She has been a member of AORN since 1984, was appointed to the AORN Presidential Commission for Patient Safety from 2002 to 2006 and the Advanced Practice Nursing Task Force from 2008 to 2010. She also participated as a Subject Matter Expert in the development of the Recommended Practice Guideline supporting Medication Safe Practices; presented at numerous nursing conferences both nationally and internationally; authored 18 articles in peer reviewed publications; co-authored three book chapters and five national practice standards/position statements, and was a contributing author for a national "white paper," several national tool kits, and educational programs all focused on enhancing patient safety across the perioperative continuum of care. And lastly, she was the recipient of AORN's 2012 Award for Excellence in Perioperative Nursing.

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Historical Background

1960 – Introduction of CPR
   (Loertscher, Reed, Bannon, & Mueller, 2010)
1974 – Medical record documentation
   (Loertscher et al, 2010)
1976 – First hospital policy on DNR
   (Loertscher, et al, 2010)
1976 – Karen Ann Quinlan
   (Smith, 2000)
1990 – Cruzan vs Missouri Dept of Health
   (Smith, 2000)

Patient Self-Determination Act (PSDA)

➢ All hospitals receiving Medicare and/or Medicaid funding are required **BY LAW** to provide patients information on their rights to make decisions regarding advanced directives upon their admission to the healthcare facility.

➢ Additionally healthcare facilities:
   ➢ Must inquire if the patient already has an advance health care directive, and make note of this in their medical records;
   ➢ Provide education to their staff about advance health care directives; and
   ➢ Are not allowed to discrimately admit or treat patients based on whether or not they have an advance health care directive.
Policy on Perioperative DNR Orders

"Policies automatically suspending DNR orders or other directives that limit treatment prior to procedures involving anesthetic care may not sufficiently address a patient’s rights to self-determination in a responsible and ethical manner. Such policies, if they exist, should be reviewed and revised, as necessary, to reflect the content of these guidelines"

(American Society of Anesthesiologists [ASA], 2008)

Perioperative DNR Ethical Principles

Patient Autonomy
- The right to make informed decisions and the right to self-determination
  (Martin, Soifer, & Stevens, 1991)

Non-maleficence
- An obligation not to inflict harm to others
  (Smith, 2000)

Beneficence
- The goal of doing good
  (Beauchamp & Childress, 2001)

Justice
- Fair distribution of care
  (Beauchamp & Childress, 2001)
Ethical Issue in the Perioperative Environment

Automatic revocation of DNR orders in the perioperative environment in direct defiance of PSD
(Smith, 2000)

Preservation of patient autonomy
(ACS, 1994; AORN, 2011; ASA, 2008)

Adherence to informed consent
(ACS, 1994; AORN, 2011; ASA, 2008)

Physician sense of beneficence
(Smith, 2000)

Perioperative DNR Considerations

PSDA makes no special provision for DNR status of surgical patients
(Ewanchuk & Brindley, 2006; Smith, 2000)

Almost 15% of patients with DNR orders require surgery
(Smith, 2000)

Blanket rescinding of DNR orders during perioperative phase
(Ewanchuk & Brindley, 2006; Smith, 2000)
Case Study: Ethical Considerations

Autonomy
- Family and physician designated DNR status
- Informed consent: Anesthesia consult with family prior to tracheostomy revealed family wishes to treat all untoward events in perioperative period

Beneficence
- DNR rescinded during perioperative period then re-established 2 days post-op

DNR Orders in Surgery

Before the 1990s, formal DNR policies in surgery were non-existent (Ewanchuk & Brindley, 2006)

Common practice: Automatic suspension for surgical patients (Ewanchuk & Brindley, 2006)

Compromise autonomy and self-determination to receive surgery (Ewanchuk & Brindley, 2006)

1993: Required Reconsideration policy changed the standard of practice (ASA, 2008; Ewanchuk & Brindley, 2006)
Where Do You Stand?

- Does your organization have a policy on DNR in the operating room?
- Is your policy to automatically suspend DNR orders for surgical patients?
- Who has adopted the Required Reconsideration policy to re-evaluate, re-consider or possibly modify DNR orders to meet the patients wishes?

Three Courses of Action

Following informed consent by the anesthesia provider, the patient, family or surrogate is empowered to choose the course of action desired:

- Rescind DNR order;
- Leave DNR order in place; or
- Establish a new DNR order with list of procedures/ interventions approved by the patient.

(ASA, 2008; Ewanchuk & Brindley, 2006)
Three Types of DNR Orders

Procedure Directed DNR
- Checklist of patient or surrogate approved resuscitative interventions
  (Fallat & Deshpande, 2004; Mittleberger, Lo, Martin, & Uhlmann, 1993)

Goal Directed DNR
- With patient goals and preferences in mind, provider aligns medical situation with goals to determine resuscitation needs
  (Fallat & Deshpande, 2004; McBrien & Heyburn, 2006)

Futility-Based DNR
- Unilateral decision by the provider in regards to DNR status
  (Fallat & Deshpande, 2004)

Perioperative Challenges
- Lack of knowledge by the perioperative team regarding patients DNR status or end-of-life wishes
- Clinical situations may arise in the operating room or postoperatively that are reversible with resuscitative medications
- Death in the operating room does not allow for patient dignity
  (Ewanchuck & Brindley, 2006)
Obligations of the Provider in Surgery

- Surgeon/anesthesia provider discuss previous DNR order
- Document discussion and patient/family/surrogate final decision
- Communicate patients wishes with entire perioperative team (inclusive of postoperative staff)

(ACS, 1994; AORN, 2011; Ewanchuck & Brindley, 2006)

Obligations of the Perioperative Team

- Honor patient’s right to self-determination
- Unethical to place own values and beliefs on patient
- Members of the surgical team should be replaced if unable to comply with patient end-of-life wishes
- Patient or family should not fear they will be treated differently based on the DNR order chosen
- Patient should never have to choose between autonomy or the surgical procedure

(Ball, 2009; Fallat & Deshpande, 2004; Phillips et al., 1996)
Supporting Patient Autonomy: Health Policy

- Develop clear, standardized guidelines (Lo, 2006)
- Integrate process that requires timely end-of-life discussions to facilitate advanced planning (Morrell, Brown, Qi, Drabiak, & Helft, 2008)
- Develop policies that require documentation of end-of-life discussions and final decisions made (Lo, 2006; Morrell et al., 2008)

Supporting Patient Autonomy: Health Policy (con’t)

- Incorporate systems interventions to improve identification of DNR patients (electronic medical record) (Lo, 2006)
- Develop policies integrating DNR status in all hand-off communication (Lo, 2006)
- Change acronym from DNR to AND – “Allow Natural Death” (Vennemann, Naranor-Harris, Perlsh, & Hamilton, 2008)

Call-to-Action
Implications for Nursing Practice

- Be the patient and family advocate
- Perioperative team needs to be aware of the hospital DNR policy in surgical settings
  \(\textit{\cite{Coopmans & Greis, 2001}}\)
- Ensure discussion of DNR order and final decision is documented and communicated
  \(\textit{\cite{Lo, 2006; Morrell et al., 2008}}\)
- During transitions of care, communicate DNR status as part of \textit{hand-off} procedures
  \(\textit{\cite{Lo, 2006}}\)

Implications for Nursing Practice (\textit{con't})

- Consult with ethics experts when difficult situations arise
  \(\textit{\cite{Ball, 2009}}\)
- Seek membership/involvement in ethics committee
  \(\textit{\cite{ANA, 2003}}\)
- Nurses should play an active role in the process of initiating DNR discussion
  \(\textit{\cite{Sulmasy, He, McAuley, & Ury, 2008}}\)
Implications for Practice: Education and Research

Nursing Education
- Biomedical ethics concepts
- Health policy
- Communication strategies

Nursing Research
- Systems and process support:
  - End-of-life discussions for DNR patients
  - Peaceful death for surgical patients with a DNR order

Conclusion

“Doing NOTHING...is in fact doing SOMETHING!”

“Do not resuscitate does not mean NO CARE...”

“...it means a DIFFERENT kind of care!”

(Vennemann, Narnor-Harris, Perish, & Hamilton, 2008)
References: