

**ETHICAL GUIDELINES FOR THE ANESTHESIA CARE OF PATIENTS
WITH DO-NOT-RESUSCITATE ORDERS OR OTHER DIRECTIVES
THAT LIMIT TREATMENT**

Committee of Origin: Ethics

**(Approved by the ASA House of Delegates on October 17, 2001, and last affirmed on
October 22, 2008)**

*These guidelines apply to competent patients and also to incompetent patients
who have previously expressed their preferences.*

- I. Given the diversity of published opinions and cultures within our society, an essential element of preoperative preparation and perioperative care for patients with Do-Not-Resuscitate (DNR) orders or other directives that limit treatment is communication among involved parties. It is necessary to document relevant aspects of this communication.
- II. 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.
- III. The administration of anesthesia necessarily involves some practices and procedures that might be viewed as "resuscitation" in other settings. Prior to procedures requiring anesthetic care, any existing directives to limit the use of resuscitation procedures (that is, do-not-resuscitate orders and/or advance directives) should, when possible, be reviewed with the patient or designated surrogate. As a result of this review, the status of these directives should be clarified or modified based on the preferences of the patient. One of the three following alternatives may provide for a satisfactory outcome in many cases.
 - A. Full Attempt at Resuscitation: The patient or designated surrogate may request the full suspension of existing directives during the anesthetic and immediate postoperative period, thereby consenting to the use of any resuscitation procedures that may be appropriate to treat clinical events that occur during this time.
 - B. Limited Attempt at Resuscitation Defined With Regard to Specific Procedures: The patient or designated surrogate may elect to continue to refuse certain specific resuscitation procedures (for example, chest compressions, defibrillation or tracheal intubation). The anesthesiologist should inform the patient or designated surrogate about which procedures are 1) essential to the success of the anesthesia and the proposed procedure, and 2) which procedures are not essential and may be refused.
 - C. Limited Attempt at Resuscitation Defined With Regard to the Patient's Goals and Values: The patient or designated surrogate may allow the anesthesiologist and surgical team to use 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, some patients may want full resuscitation procedures to be used to manage adverse clinical events that are believed to be quickly and easily reversible, but to refrain from treatment for conditions that are likely to result in permanent sequelae, such as neurologic impairment or unwanted dependence upon life-sustaining technology.
- IV. Any clarifications or modifications made to the patient's directive should be documented in the medical record. In cases where the patient or designated surrogate requests that the anesthesiologist use clinical judgment in determining which resuscitation procedures are appropriate, the anesthesiologist should document the discussion with particular attention to the stated goals and values of the patient.

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- V. Plans for postoperative care should indicate if or when the original, pre-existent directive to limit the use of resuscitation procedures will be reinstated. This occurs when the patient leaves the postanesthesia care unit or when the patient has recovered from the acute effects of anesthesia and surgery. Consideration should be given to whether continuing to provide the patient with a time-limited or event-limited postoperative trial of therapy would help the patient or surrogate better evaluate whether continued therapy would be consistent with the patient's goals.
- VI. It is important to discuss and document whether there are to be any exceptions to the injunction(s) against intervention should there occur a specific recognized complication of the surgery or anesthesia.
- VII. Concurrence on these issues by the primary physician (if not the surgeon of record), the surgeon and the anesthesiologist is desirable. If possible, these physicians should meet together with the patient (or the patient's legal representative) when these issues are discussed. This duty of the patient's physicians is deemed to be of such importance that it should not be delegated. Other members of the health care team who are (or will be) directly involved with the patient's care during the planned procedure should, if feasible, be included in this process.
- VIII. Should conflicts arise, the following resolution processes are recommended:
 - A. When an anesthesiologist finds the patient's or surgeon's limitations of intervention decisions to be irreconcilable with one's own moral views, then the anesthesiologist should withdraw in a nonjudgmental fashion, providing an alternative for care in a timely fashion.
 - B. When an anesthesiologist finds the patient's or surgeon's limitation of intervention decisions to be in conflict with generally accepted standards of care, ethical practice or institutional policies, then the anesthesiologist should voice such concerns and present the situation to the appropriate institutional body.
 - C. If these alternatives are not feasible within the time frame necessary to prevent further morbidity or suffering, then in accordance with the American Medical Association's Principles of Medical Ethics, care should proceed with reasonable adherence to the patient's directives, being mindful of the patient's goals and values.
- IX. A representative from the hospital's anesthesiology service should establish a liaison with surgical and nursing services for presentation, discussion and procedural application of these guidelines. Hospital staff should be made aware of the proceedings of these discussions and the motivations for them.
- X. Modification of these guidelines may be appropriate when they conflict with local standards or policies, and in those emergency situations involving incompetent patients whose intentions have not been previously expressed.