Department of Surgery
Grand Rounds / RSS Session
University of Colorado Denver School of Medicine

Presenter Financial Disclosure Slide

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"ETHICAL ISSUES IN PERIOPERATIVE DNR PATIENTS"

Dr. Abbott does not have any relevant commercial financial relationships to report.

Dr. Abbott does not intend to reference off-label/unapproved uses of products or devices in this presentation.

Special Thanks

- Peri-operative Team:
  - Nicole Babu
  - Barb Krumbach
  - Michelle Ballou
  - Nicole Routh
- Dr. Marina Shindell, anethesia

They've done the hard work: research, policy comparisons, draft algorithm, Policy, new DNAR form – now in draft form

Goals today:

- Review some of the cases that trouble us
- How did we get here?
- Consider professional standards and responsibilities
- Framework for approaching "DNR" patients
- Think about some conversation starters and stoppers
- Review policy in progress

What to do?

- 65 y/o gentleman s/p liver transplant, presents for umbilical hernia repair in Day surgery. His PMH significant for liver transplant about a year, prior, complicated rejection, a prolonged hospital stay, ARDS (probably transfusion-related) intubation and trached. He eventually recovered.
- His wife and he are adamant about DNR status. He states that he does not want to be intubated either.
- But hernia bothers him enough to want this surgery.

- What does having a "DNR" form mean?
- How successful is CPR?

What does a "DNR" form mean?

- If respiratory arrest, no ventilation/intubation
- If heart stops, no CPR, defibrillation.

How successful is CPR:

- >60% on TV
- 5-10% in community
- 6-32% - in-hospital arrests
  - 44% of survivors have significant decline in functional status.
- 65% of OR arrests survive to DC.
- 92% of arrests caused by anesthesia survive

How big a problem?

- How many have done procedure on a “DNR” patient?
- The numbers: 15% of DNR patient will have a surgical procedure?
- Why increasing?

Surgeon’s Perspective:
What problems do “DNR” wishes pose?

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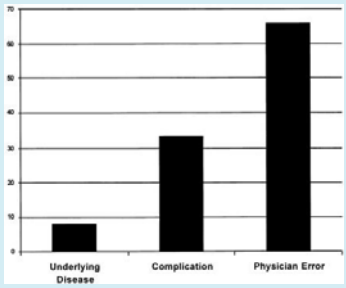
What problems do “DNR” wishes pose?

- Does not include what to do before the arrest?
- The context is often not clear to patient
  - Anesthesia takes over resuscitative functions
  - Pain meds may cause transient apnea
  - Traction on viscera can cause PEA
- Medical treatments performed in groupings to work effectively – menu or “partial” DNRs are problematic.
- Professional integrity and purpose
- Surgery statistics are monitored

Would physicians override a DNR Order when a Cardiac Arrest is Iatrogenic? Casarett, J Gen Intern Med, 1999



What to do?

- 65 y/o gentleman s/p liver transplant with multiple complications…., presents for umbilical hernia repair…..
- His wife and he are adamant about DNR status. He states that he does not want to be intubated either.
- But hernia bothers him enough to want this surgery.
- Choices?

What are common patient wishes in face of overall DNR?

- Suspend DNR during surgery
  - How long?
- *…..middle*
- Honor at all times

What does the middle look like?

- *Life is OK, but barely.*
- *I want this surgery enough to respect MD needs*
- *You have to ask "why"*

What do patients want near end of life?

- Adequate pain and symptom management
- Avoid inappropriate prolongation of dying
- Sense of control
- Relieving burdens from others
- Strengthening relationships with loved ones
- Less concern to accuracy of surrogate decisions that causing stress****

Singer, et al. Quality End-of-Life Care: Patient Perspectives, JAMA 1999.
Berger JT. J Clin Ethics 2009.

Why does a patient with a DNR wish get surgery?

Why does a patient with a DNR wish get surgery?

- Palliative:
  - Pain relief
  - Bowel obstruction relief
  - Easier breathing
- Unrelated to life-limiting disease
- "Hail Mary"
  - Lung reduction surgery consult
- Emergent rescue with confusion

Patient Perspectives:

Clemency, 1997.

- DNR intentions:
  - Avoid compromised life, family burdens
  - These can vary widely!
- Desired surgery:
  - Pain relief, enhanced quality of life.
- DNR does not mean "Do Not Care"
- Goal-directed vs. procedure-directed modifications

Goal-directed modifications

- Resuscitative efforts only if adverse clinical events believed to be both temporary and reversible.
- Trust judgment of anesthesiologist, surgeon, caregivers.
- Based on context & understanding of patient values and goals of treatment.

Procedure-directed modifications

- Full resuscitation measures….
- Exception of specific procedures:
  - CPR (most common)
  - Cardioversion?
- Understanding that some resuscitative-type procedures are essential to anesthetic care.
- Provides clarity, esp. across caregivers
- May not be in line with intentions

The adamant patient….

- 60 y.o. UH staff member with longstanding Barrett's esophagus requiring biopsies, dilatation and repeated endoscopy.
- DNR in chart for several years. Repeatedly asks for renewal.
- PEA arrest in Endo Suite. Given atropine, < 30 seconds of CPR done.
- Angry (for several years following) at failure to honor his DNR.

Does the patient have all the "say"?

- Non-beneficial care: no obligation to offer
- Medical futility:
  - Goal futility – intervention has low probability of improving outcome
    - needs physician input
  - Value futility – defined goal not worth achieving to patient/surrogate

Surgical "buy-in":

Schwarze, et al, Crit Care Med 2010.

- Strong sense of responsibility for outcomes
- Complicated negotiation required
- Contracting with patients
- "This is a package deal"

When did the American College of Surgeons say this?

- "the best approach is a policy of 'required reconsideration' of previous advance directives."
- "An institutional policy of *automatic cancellation* of the DNR status in cases where a surgical procedure is to be carried out removes the patient from appropriate participation in decision making. *Automatic enforcement* without discussion and clarification may lead to inappropriate perioperative and anesthetic management."

WHAT IF YOU DISAGREE OR AREN'T WILLING TO TAKE THE RISK?

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OK to decline to do intervention. Not OK to abandon the patient – refer to another physician.

Surgery unrelated to Life-limiting illness

- Mrs. P is a 74-year-old woman presenting for emergent treatment of a fracture-dislocation of her right hip, suffered in a fall at her nursing home. She appears frail, but is alert and oriented. She is accompanied by her daughter, and both state that they want her to receive full medical care. She offers you a MOST form brought from her nursing home.
- What do you do?

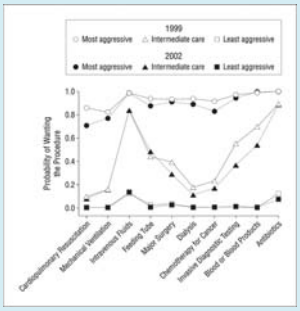
What do we know about Advance Directives?

- Types: "No CPR", purple DNAR, MDPOA, 5 Wishes,
  - Colorado MOST form – Orders
- Not often done (25% of people)
- Change over time
- Different meanings
- May increase interventions due to increased reliance on "papers"

MOST Form

- Colorado Medical Orders for Scope of Treatment
- Legislated July 2010
- Orders – not wishes
  - ***Does not replace "goals of care" conversation***
- Portable
- Signed by physician, APN, PA.
- To be reviewed, changed, dated as needed.
- Vulcan green – but any color, FAXed copy OK.

Probability of desiring specific interventions given category of desire for aggressiveness of care in 1999 and in 2002



Wittink, M. N. et al. Arch Intern Med 2008;168:2125-2130.

ARCHIVES OF INTERNAL MEDICINE

Mrs. P: Woman with hip fracture

- Wants full resuscitation except for CPR.
- Only until done in the OR.
- 3 days post-op she develops V tach.
- A Code is called.
- What do you do?

Time Limitations on DNR modification/suspension

- When patient leaves care of anesthesiologist
- Surgical complications
  - Extended ventilation?
  - Extended vasopressors?
  - ……

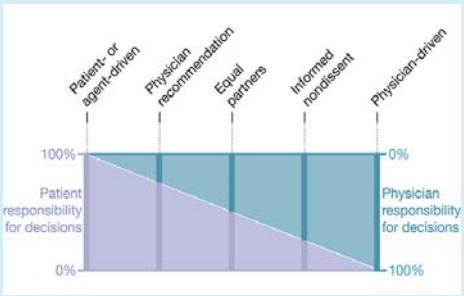
How are decisions made these days in the OR, in Chronic Illness?

-Leg amputation

-Pelvic exenteration

-Lobectomy…..

Figure. Shared Decision-Making Continuum



Kon, A. A. JAMA 2010;304:903-904

JAMA

Current decision making models

(Epstein & Peters, 2009)

- Paternalism (not considering the patient)
- Naïve consumerism (giving patients what they initially ask for)
- Abandonment dressed as autonomy "go home, think about it, and let me know"

YOU….are part of the process.

Beyond Information: Exploring Patients' Preferences

Epstein & Peters, JAMA 2009.

- Stable preferences vs. "Constructed" preferences
- Instability: unfamiliar, high-stakes, uncertain situations.
- "Choiceless choices"
- Inability to imagine the treatment ordeal, even when well informed.
- Need guided conversations – give and take.

THE INDEX CASE

- Patient with aggressive squamous cell CA of the head, progressive despite radiation, chemo and surgery.
- One day after completing radiation to spleen, developed severe abdominal pain, Dx with bowel perforation. Attempted non-surgical management failed.
- Patient had registered DNR, wife MDPOA at MD's office. Wife advocate and reminded people of DNR.
- In pre-op, anesthesia staff informed patient that surgeons had inactivated the DNR order.
- Rationale to wife: "Consent for surgery means patient wants to live, and therefore DNR does not apply."

What could we do better?

What could we do better?

- Conversations earlier.
- No indirect communication.
- No mis-information – consent does NOT in itself mean DNR wishes are void.
- Step back from technical "success" to hearing patient hopes and fears.

WITHOUT A PROCESS

- 72 year old woman admitted in the middle of the night with hip fracture. Patient was scheduled for an add-on hip pinning sometime the next day.
- Patient had a CPR directive from the outside.
- Patient told she could not be DNR until after her hip surgery.
- No paperwork filled out to document that any discussion had taken place with the patient regarding her DNR.

Towards Better Care of "DNR" Patients

- Systematic process
- Conversation BEFORE pre-op area
- Focus on goals, not technicalities
- Document
- Share with all personnel
- Anesthesia to ***confirm*** special issues with anesthesia
- Establish a reinstatement time

- ACS suggestion on permit form….

  "In preparation for your operative procedure and the immediate postoperative period, your advance directive (such as DNR) may need to be modified. If you currently have such an advance directive, it should be discussed with your surgeon and anesthesiologist prior to the operative procedure."

Who is responsible to clarify DNR?

	Inpatient	Outpatient	
Convenience	Primary physician	Pre-op Clinic visit	
Emergent	Primary/surgeon/anesthesia	ER? -- ER plus consulting surgeon	

Primary physician: Is this surgery in line with your values, wishes, needs?
Surgeon: Chances of achieving goals? Risks? What if we don't succeed?
Anesthesia: What if there is an airway, medication problem? Big picture for resuscitation goals.

Purpose of the pre-op encounter just before surgery – to confirm patient wishes as documented and remind patient of special peri-operative risks.

Discussion in the Pre-Op Area:

- Medical Miranda warning
- Patient as hostage.
- Patient without insight.
- Uninformed consent.

- IS needed by Anesthesia to confirm the particular parts of anesthetic process that are unique to DNR – either way.

Our job is to recommend interventions that are in line with goals and values and to discourage those that are not…..but be open to "push back"!

Don't start with procedures….
Ask "why?" – Establish goals

Having the Conversation

- Unhelpful:
  - If you don't have this procedure you will die.
  - Do you want us to "do everything."
  - There is nothing more we can do.
- Helpful:
  - Here's what we would hope to do with ____
  - What are your goals? What's most important for you?
  - What are you most afraid of?

- "If a patient's heart stops in the operating room, resuscitation is much more likely to be successful than in other circumstances."
- I'd like to discuss with you what level of resuscitation will be provided in the operating room or how care might be limited.

- "Giving anesthesia can be very similar to resuscitation. For example, drugs to support blood pressure and measures to maintain breathing are used in the operating room and in resuscitation. In the operating room, these treatments allow the anesthesiologist to keep you sedated and pain-free during the operation, while sustaining your breathing and circulation."

Documentation for Palliative procedure

- 40s male with ESLD and ascites scheduled for umbilical hernia repair;
- "Patient has DNAR. Discussed with family and patient and we will keep DNAR in force, except for temporary and reversible events. Patient understands that general anesthesia will involve intubation and hemodynamic support. But we will not do CPR if it becomes an issues. Discussed with General Surgery Attending."

--- Anesthesia Faculty

WITHDRAWAL OF TREATMENTS: THEORETICAL FRAMEWORK

- Intuitively: acts of commission seem ethically more problematic than acts of omission:
  - i.e. don't start

  But…..
- "Only after starting treatments will it be possible, in many cases, to make a proper diagnosis and prognosis, as well as to balance prospective benefits and burdens."

Beauchamp & Childress: Principles of Biomedical Ethics

Conclusion

- You MUST have a conversation with patient or surrogate to understand the meaning of DNR and possible modifications for surgery.
- This must occur in time for the patient to reflect on choices – and there are always choices!
- Document and share decisions with providers.
- Clarify a reinstatement time.