Position Statement

American Society of PeriAnesthesia Nurses

A Position Statement on the Perianesthesia Patient with a Do-Not-Attempt-Resuscitation (DNAR) Advance Directive

Synopsis[1]

The American Society of PeriAnesthesia Nurses (ASPAN) has a responsibility to define principles of safe, quality nursing practice in the perianesthesia setting. ASPAN, therefore, has the responsibility to assist in defining and supporting guidelines for the provision of ethically sound care during the perianesthesia period. It is unethical to automatically rescind do-not-attempt-resuscitation (DNAR) orders during anesthesia. Patients have the right to retain their DNAR orders unaltered or modify them for the perianesthesia period.[2] Ethical care during the perianesthesia period requires that the nurse act in accordance by providing humane and just care with knowledge of the patient's predetermined end-of-life wishes. The perianesthesia registered nurse's ethical responsibilities encourage advocacy to assure a preanesthesia patient's consent is truly informed, autonomous, and self-determined. The nurse also demonstrates respect by facilitating holistic concern for the perianesthesia patient's emotional, spiritual, and educational well-being while providing physical safety. The overarching aim is to identify the patient's goals for care and to ensure the preoperative, intraoperative, and postoperative care teams decisions align with the patient's wishes.[2]

A patient (and/or designated surrogate[a]) whose advance directive specifies no life sustaining measures may be unaware that cardiac or respiratory arrest are always potential outcomes associated with anesthesia. When the patient's desires for the perianesthesia period are not specifically identified, anesthetic-related changes in physiologic function present the perianesthesia registered nurse with ethical conflict and confusion about appropriate interventions.

Background

1. The commonly used Do-Not-Resuscitate (DNR) order can be misleading, as it suggests that resuscitation will be successful if attempted. The term Do-Not-Attempt-Resuscitation (DNAR) is clearer and is used throughout this position statement, although each facility may use a variety of terms to describe these end-of-life requests [DNR, DNAR, Do-Not-Intubate (DNI), or Allow Natural Death[b] (AND)]. These requests reflect patient preference for a "dignified death" without artificial life support and life-sustaining efforts.
2. Palliative treatment or comfort care or emergency events might require anesthesia and surgery. These interventions stress physiologic function, suppress consciousness, and precipitate transient, reversible decreases in cardiac and respiratory function, but are not associated with natural evolutions toward the patient's death.

[a]A surrogate is a substitute health-care decision-maker who consents or refuses to consent to some or all medical treatment for the patient who lacks decision-making capacity.[3]

[b]Allow Natural Death (AND) is an alternative term gaining popularity regarding life sustaining measures that emphasize patient comfort and pain management as opposed to life-extending measures.[4]

3. Endotracheal intubation, mechanical ventilation, cardiovascular medications, cardiopulmonary resuscitation, and defibrillation/cardioversion are often specifically restricted in an advance directive. Many procedures requiring anesthesia require the use of intubation techniques and mechanical ventilation to protect the airway for the duration of the anesthesia. The patient, family and/or legal representative may not be aware that some of these interventions are routinely used to support vital organ functioning during the perianesthesia period.
4. Assuming the patient's wishes or applying a facility policy or medical decision that automatically suspends any patient's DNAR directive during the perioperative[c] period denies the patient's right to self-determination and to autonomous, informed choices. The perianesthesia registered nurse is intimately involved in determining patient readiness for procedures and often is the "first-responder" who witnesses, then collaborates with physicians and anesthesia professionals to intervene and evaluate the outcomes of respiratory and/or cardiac arrest. Unclear communications and ambiguous or nonexistent facility policies about a patient's DNAR status during the perianesthesia period do not direct and support a nurse's decisions and actions. Ethically, this nurse must choose between not responding, thereby doing harm (maleficence), and a professional and legal obligation to preserve life without harm (beneficence). These choices may conflict with the patient's stated end-of-life choices.

[c] *'Perioperative period' is defined as the total surgical experience and includes pre-, intra-, and postoperative phases of the patient's surgical journey.*[5]

Position

The American Society of PeriAnesthesia Nurses (ASPAN) recommends the following:

1. Patients have the right to retain their DNAR orders unaltered or modify them for the perianesthesia period.[2]
2. At the time of surgery and prior to receiving any anesthetic medication, a patient with an active DNAR advance directive and/or assigned surrogate will be asked to re-clarify wishes about resuscitation during the perianesthesia period.
    a. "Required reconsideration"[d] discussion of existing DNAR orders.
    b. This discussion will include clarification of the intrinsic nature of anesthesia and resultant measures to protect cardiovascular and respiratory functions during the administration of anesthesia.
3. To limit potential for ethical dilemmas, the patient's informed consent will include a thorough review of the advance directive, living will, or physician order that specifies DNAR during a candid conversation with physicians and appropriate family designee(s).
    a. Careful documentation of the discussion must be completed.

[d] *"Required reconsideration" involves a goal-directed discussion among patients, surrogates, and their treating physicians regarding the extent of resuscitative measures to be exercised during the perioperative encounter, to include defining a time frame for alterations and revocation of the DNAR order.*[4,6,7,8]

4. Each facility should establish and communicate a policy identifying resources and procedures detailing the management of a patient's DNAR status during the perianesthesia period.[d,e,f,g]
5. Each facility should establish and communicate policies that protect patient dignity, rights, and autonomy, and do not automatically suspend the DNAR status without a detailed and documented discussion of the risks, benefits, and alternatives to the procedure as well as the desire of the patient to allow the DNAR to be suspended or not.
6. Where the perianesthesia registered nurse's personal convictions prohibit participation, that nurse may remove himself or herself from a patient care situation, as long as such removal does not harm the patient or constitute a breach of duty. The professional nurse should provide his or her manager with information about the specific situations in which it would be difficult to participate so that the manager is better able to plan for patient needs.

   However, if an unplanned situation arises in which no other registered nurse is available to care for the patient, then the objecting nurse must ensure that the care needs of the patient are met.[1] (Refer to Perianesthesia Principles for Ethical Practice.)

[e]For information on the American Society of Anesthesiologists' position on perioperative do-not-resuscitate orders, visit the ASA website at http://www.asahq.org/.[9]

[f]For information on the Association of periOperative Registered Nurses' position on perioperative do-not-resuscitate orders, visit the AORN website at http://www.aorn.org.[11]

[g]For information on the American Association of Nurse Anesthesiology's practice guideline, "Reconsideration of Advance Directives," visit the AANA website at https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/reconsideration-of-advanced-directives.pdj?sfvrsn=550049b1_6.[10]

Approval of Statement

This statement was approved by a vote of the ASPAN Board of Directors on April 20, 1996, in Phoenix, Arizona. ASPAN joins other professional colleagues, specifically the American Nurses Association (ANA), the American Society of Anesthesiologists (ASA)[e], and the Association of periOperative Registered Nurses (AORN)[f] in considering the ethical implications of the advance directive.

This position statement was updated and revised at the October 2021 virtual meeting of the Standards and Guidelines Strategic Work Team in Cherry Hill, NJ.

ASPAN expresses appreciation to the following organizations for signing on in support of this position statement:

- American Association of Nurse Anesthetists[g]
- Association of periOperative Registered Nurses

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ADDITIONAL READING

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"The resuscitation status of all patients brought into the perioperative care setting should be documented explicitly. For the avoidance of error and confusion, this is particularly important in the case of patients who are or who have been DNR. For those patients in particular, an entry in the chart should document whether the existing DNR status remains in force and, if not, how it is to be modified upon admission to perioperative care and upon discharge from perioperative care. Any ambiguity should be addressed with and by the surgeon of record."

DNR/DNAR/DNI CHECKLIST GUIDE FOR NURSES DATE:_____

SETTING	RESPONSIBILITY / ACTION	YES	NO	N/A
Pre Admission or Inpatient – Day(s) Before Surgery	• *Advance directives and DNR/DNAR/DNI in the patient's chart* • *DNR/DNAR/DNI surgeon's orders (retain or suspend) and intervention plan.*			

PREOP (on the day of surgery)	**PREOP NURSE:**
	• *Check and review advance directives.*
	• *Check surgeon's DNR/DNAR/DNI order and intervention plan.*
	• *Contact surgeon for clarification:*
	  ○ *If no DNR Suspension surgeon's order and no intervention plan on patient with existing DNR/DNAR/DNI.*
	  ○ *If there is a conflict or unclear DNR/DNAR/DNI documentation, patient's advance directives and physician's consent.*
	• *Check informed consent for anesthesia care, e.g. type of resuscitation and duration of intervention plan.*
	• *Assess patient or surrogate decision maker's concerns and issues related to DNR/DNAR/DNI and communicate to physicians as indicated.*
	• *Provide hand off to OR Nurse.*
	***NOTE**: If a nurse has an ethical discomfort/concern, inform Nurse Manager to resolve ethical conflict or concern by finding someone who is not bothered by the current state of affairs.*			

INTRAOP	**OR NURSE:** • *Receive hand off report from Preop Nurse* • *Implement necessary actions to be taken* ***NOTE**: If a nurse has an ethical discomfort/concern, inform Nurse Manager to resolve ethical conflict or concern by finding someone who is not bothered by the current state of affairs.*			
Post Anesthesia Care Unit (Phase I)	**DURING HANDOFF REPORT:** • *Receive hand off report from anesthesia provider and OR Nurse.* • *Check physicians' DNR/DNAR/DNI orders, intervention plan, and duration of implementation time.* • *Check change in physician's order to resume DNR/DNAR/DNI and effective time.* • *Obtain clear intervention plan throughout the length of PACU stay and upon transfer.* • *Provide hand off report to the receiving nurse upon transfer to the next level of care.*			

