DO NOT ATTEMPT RESUSCITATION (DNAR) ORDERS

Owner: Associate Medical Director for Inpatient Care

Associate Medical Director for Ambulatory Care

Purpose: To provide information to providers about DNAR orders that may be shared with patients

Policy: It is appropriate for Do Not Resuscitate Orders to be initiated in situations where there is consensus that CPR would not be effective or when a well-informed competent patient chooses to refuse resuscitation.

Procedure:

BACKGROUND

In order to evaluate the issues surrounding a DNAR order, it is first necessary to understand the indications for, and outcomes of, CPR. The purpose of cardiopulmonary resuscitation (CPR) is to restore adequate circulatory and respiratory function in an effort to avert the sudden death of a patient. Information from the medical literature suggests that the immediate success of in-hospital resuscitation is 30-40%, and it is estimated that 15% survive long enough to leave the hospital. Long-term survival is much less likely in patients with preexisting hypotension (2%), sepsis (0%), pneumonia (0%), stroke (0%), renal failure (3%), metastatic cancer (0%), home-bound life-style (4%), or age>70 (0-2%).

A well-informed and competent patient has the right to refuse resuscitative efforts even when those efforts would be medically appropriate. Likewise, a surrogate decision maker for an incapacitated patient may exercise such a right on behalf of the patient based on a substituted judgment that the patient would not want such an intervention. In such cases, the attending physician, after ensuring that such a decision is based on an understanding of the risks and potential benefits of CPR, should write a DNAR order.

In addition to a patient initiated DNAR decision, clinicians must also determine the medical appropriateness of resuscitative efforts in a particular case. Just as clinicians must decide when ongoing resuscitative efforts are no longer medically appropriate, there are also some patients in whom initiation of CPR may not be medically appropriate. These would include situations where there is reasonable medical certainty that CPR would not be effective at restoring circulation or, even if successful, would not offer meaningful benefit to the patient. In these situations, the responsible clinician is expected to complete the Do Not Attempt Resuscitation (DNAR) order form and document the rationale for restricting resuscitative efforts in the Progress Notes. As patients and families have often come to expect CPR and other resuscitative efforts to be instituted automatically in the event of death, the patient and/or family should be notified that CPR will not be provided and the rationale for this decision.

Regarding discussions of a DNAR order, the following considerations should be kept in mind:

1. In almost all U.S. hospitals, a patient will receive CPR in the event of a cardiac arrest unless a specific DNAR order is written.
2. The attitudes among individual patients as to the circumstances under which they would or would not apply resuscitative efforts or other aggressive medical care vary widely.
3. Although some individuals, even when quite ill, make very definite choices as to what medical care they desire, others, even if mentally alert and competent, are reluctant or uncomfortable in making such choices for themselves.
4. A majority of the public has neither a “living will” (also called an “advance directive”) nor a durable power of attorney for health care matters. Hospitals are required to ask whether such documents exist at the time of every admission (Patient Self Determination Act).

5. If there is a difference of opinion between the members of the medical team or the patient, family, and the medical team an ethics consult may be warranted.

Policy:

Given the considerations above, a discussion regarding resuscitation should take place to examine the understanding and preferences regarding resuscitation of any seriously and/or chronically ill patient admitted to the inpatient service. A summary should be documented in the record. This is true even if an advance directive has been previously executed.

Addendum: DNAR ORDERS IN THE SPECIAL CIRCUMSTANCES OF ANESTHESIA AND SURGERY

References: N/A

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DNAR ORDERS IN THE SPECIAL CIRCUMSTANCES OF ANESTHESIA AND SURGERY

1. Existing DNAR orders are not automatically rescinded, but will be reconsidered in patients who require surgery or anesthesia.

2. If the discussion process described below cannot take place due to a recognized medical emergency, care will proceed being mindful of the patient’s known goals and values and with all possible reasonable adherence to the patient’s directives under the circumstances.

Procedure:

1. Patients who have current and valid DNAR orders, and who present for surgery or anesthesia will be identified to the Anesthesia Department by the attending surgeon or his/her representative at the time of the scheduling the surgery or procedure whenever possible.

2. The attending anesthesiologist will consult as necessary with the patient’s attending physician/surgeon in order to acquire information regarding the patient’s clinical situation.

3. The anesthesiologist will meet with the patient and/or other relevant persons, including, as applicable, the patient’s legally authorized surrogate decision-maker. The patient’s personal physician or surgeon may be present.

4. Discussion with the patient will follow the usual process for informed consent including, but not limited to, the following elements:
   a. Exploration of any elements deemed necessary to ensure understanding by the patient of the special nature of surgery and anesthesia as they relate to the DNAR orders.
   b. Explanation of the concepts of the effects of anesthesia persisting into the postoperative period and the implication of this time period with respect to reinstitution of the original DNAR orders.

5. Agreement regarding the status of the patient’s DNAR status during surgery will be documented in the medical record and signed by the involved physician(s).

6. If a DNAR order has been suspended during surgery or anesthesia, a new DNAR order does not need to be written after recovery from anesthesia if the patient again desires DNAR status.

7. The patient retains the right to modify or rescind all or part of the agreements at any time.