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# To Resuscitate or Not . . . In the Operating Room: The Need for Hospital Policies for Surgeons Regarding DNR Orders

Vassyl A. Lonchyna\*

“As to diseases make a habit of two things—to help, or at least, to do no harm.”

—Hippocrates

In the wake of the deaths of national figures such as President Richard M. Nixon, First Lady Jacqueline Kennedy Onassis, and Joseph Cardinal Bernardin, Americans are exhibiting a different attitude toward dying and the care given at the end of life.<sup>1</sup> Richard Nixon had a living will<sup>2</sup> that stated he did not wish to have the assistance of a breathing machine to sustain his life. Following his stroke in April of 1994, doctors honored this advance medical directive<sup>3</sup> and allowed him to die peacefully with-

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1. Richard A. Knox, *Americans Changing How They Die*, TAMPA TRIB.-TIMES, May 29, 1994, at 18.

2. A living will is “[a] document which governs the withholding or withdrawal of life-sustaining treatment from an individual in the event of an incurable or irreversible condition that will cause death within a relatively short time, [when the individual] is no longer able to make decisions regarding his or her medical treatment.” BLACK’S LAW DICTIONARY 1599 (6th ed. 1990). Almost all states have statutes governing these written declarations. See, e.g., Illinois Living Will Act, 755 ILL. COMP. STAT. ANN. 35/1-35/10 (West 1992).

3. Advance medical directives consist of instructions by the patient while competent, including living wills and durable powers of attorney. The more information the patient divulges in the directive, the better it becomes for the health care provider and/or proxy surrogate to interpret what medical therapy to apply, especially when the patient is incapacitated. Norman L. Cantor, *Discarding Substituted Judgment and Best Interests: Toward a Constructive Preference Standard for Dying, Previously Competent Patients Without Advance Instructions*, 48 RUTGERS L. REV. 1193, 1241-42 (1996). The situations that should be considered are coma, dementia, chronic disability, and temporary incapacity to make decisions. The interventions that should be listed include cardiopulmonary resuscitation (“CPR”), mechanical ventilation, dialysis, blood transfusions, nutrition and hydration, antibiotics, diagnostic tests, and pain medications. Linda L. Emanuel & Ezekiel J. Emanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 JAMA 3288 (1989). Congress passed

out his life being artificially prolonged with a ventilator.<sup>4</sup> Jacqueline Kennedy Onassis refused antibiotic treatment for pneumonia after being told by doctors that there was no further therapy for the advanced lymphoma she was battling. She chose to go home and die without any further medical interventions, which would have simply prolonged the dying process.<sup>5</sup> Joseph Cardinal Bernardin discontinued further chemotherapy when he learned that pancreatic cancer had spread to his liver. He stated that he did not wish to pursue exotic methods to prolong life and accepted the natural process.<sup>6</sup>

News of the fact that these revered public figures had living wills spurred renewed public interest in advance medical directives.<sup>7</sup> It was reported that a study presented at the American Geriatric Society meeting disclosed that most dying patients and/or their families are deciding not to allow resuscitation in the event of a cardiac arrest.<sup>8</sup> The results of an American Medical Association ("AMA") survey show the ever-increasing concern of Americans about issues of medical ethics such as the medical care given at the end of life and adherence to directives such as living wills.<sup>9</sup>

In the hospital setting, cardiopulmonary resuscitation is automatically performed in the case of a respiratory and/or cardiac arrest. The legal basis for this immediate response is the presumed consent of an individual to maintain life. This treatment is withheld if there is a willful order to the contrary—in other words, a "Do Not Resuscitate" or "DNR" order. With proper communication by the attending physician and informed consent, the patient, the patient's family, or the patient's surrogate

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legislation in 1991 that requires any institution that accepts Medicare or Medicaid funds to inform adult patients and give them written information about their rights to accept or decline therapy according to the laws of the individual states, give them written policies and procedures of the institution respecting these patients' rights, and document all of this in the medical record. The Patient Self-Determination Act, Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206 & 4751, 104 Stat. 1388-115 & 1388-204 (1991) (codified in scattered sections of 42 U.S.C., especially §§ 1395cc(f) & 1396a(w) (1995)).

4. Knox, *supra* note 1.

5. *Id.*

6. Steve Kloehn, *Bernardin Ends Cancer Care, Chemotherapy Hasn't Reduced Tumor Size*, CHI. TRIB., Oct. 18, 1996, at 1.

7. *Patients Ask: "If Jackie Had a Living Will, Shouldn't I?"*, AM. MED. NEWS, June 13, 1994, at 16.

8. Knox, *supra* note 1.

9. Marilyn Chase, *Consumers Need to be Active in Debates on Medical Ethics*, WALL ST. J., Mar. 17, 1997, at B1.

may conclude that if the patient has a terminal condition, any measure to prolong life in the case of an untoward event, such as a cardiopulmonary arrest, would be futile<sup>10</sup> and, therefore, unwanted. This order is specifically entered in the medical record.<sup>11</sup>

But what happens when a patient who has a terminal condition,<sup>12</sup> who has decided to forgo extraordinary medical procedures, and who has an order countermanning resuscitation undergoes a wanted surgical procedure? Does the DNR order stand in the operating room? Because there are scarce hospital policies defining this situation, a dilemma occurs as to whether the DNR order should be adhered to, should be temporarily suspended,<sup>13</sup> or should be temporarily renegotiated.

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10. Futile means "serving no useful purpose; completely ineffective." MERRIAM WEBSTER'S COLLEGIATE DICTIONARY 475 (10th ed. 1993). It is difficult to define when medical treatment is futile. The question must be asked: "Futile in relationship to what?" Robert D. Truog et al., *The Problem with Futility*, 326 NEW ENG. J. MED. 1560, 1561 (1992). This implies a value judgment. For example, you must ask whether the likelihood that the therapy (e.g., CPR) will be effective (i.e., in resuscitating the patient) is slim, and the therapy, therefore, quantitatively futile, or whether the magnitude of the benefit is slim (e.g., the patient is resuscitated temporarily but does not survive to be discharged from the hospital) and therefore qualitatively futile. Nancy S. Jecker, *Calling It Quits: Stopping Futile Treatments and Caring for Patients*, 5 J. CLINICAL ETHICS 138, 138-39 (1994); Steven Miles, *Futility and Medical Professionalism*, 25 SETON HALL L. REV. 873, 877 (1995). Although there is no national standard of futility, communities and institutions have been encouraged to develop standards. As an example, the Santa Monica Hospital Medical Center published a definition of futile care: "Any clinical circumstance in which the doctor and his or her consultants, consistent with the available medical literature, conclude that further treatment (except comfort care) cannot, within a reasonable possibility, cure, ameliorate, improve or restore a quality of life satisfactory to the patient." *Cost-Conscious Hospitals Set Futile Care Rules*, AM. MED. NEWS, June 28, 1993, at 3. A recent collaboration of the major medical institutions in Houston, Texas, resulted in a procedural policy on medical futility. It requires participation of the physician, patient (and/or surrogate), and an institutional review board. A physician may not act unilaterally, the patient maintains the right to be transferred, and the patient is never abandoned. Amir Halevy & Baruch A. Brody, *A Multi-Institution Collaborative Policy on Medical Futility*, 276 JAMA 571 (1996).

11. See, e.g., Foster G. McGaw Hospital/Loyola University Medical Center, Administrative Policy 10-0032.17, Do Not Resuscitate 1 (May 8, 1992) [hereinafter LUMC DNR Policy] (on file with the *Annals of Health Law*).

12. A terminal condition is defined broadly as "an incurable and irreversible condition which is such that death is imminent and the application of death delaying procedures serves only to prolong the dying process." Illinois Living Will Act, 755 ILL. COMP. STAT. ANN. 35/2(h) (West 1992).

13. See, e.g., Alexian Brothers Medical Center, Administrative Policy and Procedure Manual No. 950/2050/001.00, Do Not Resuscitate Orders 7 (Nov. 1, 1991) [hereinafter Alexian Brothers DNR Policy] (on file with the *Annals of Health Law*).

This article will explain cardiopulmonary resuscitation, the legal basis for administering therapy, and DNR orders. It will describe the operating room environment and why a DNR order may be philosophically unpalatable and, therefore, untenable by the medical personnel caring for the patient. The article will then discuss three possible approaches to the problem of what to do with a DNR order of a patient going to the operating room for a procedure: (1) automatically suspend it, (2) strictly adhere to it, or (3) prior to the patient's surgery, reconsider the DNR order for the surgery time period. This article concludes that regardless of what approach a hospital takes, it must create policies to provide direction to the surgical team.

### I. WHAT IS CARDIOPULMONARY RESUSCITATION?

Cardiopulmonary resuscitation ("CPR") is the "restoration of cardiac output and pulmonary ventilation following cardiac arrest and apnea, using artificial respiration and manual closed chest compression or open chest cardiac massage."<sup>14</sup> In other words, through manual compression the heart begins to beat again, oxygen is provided by blowing it directly into the lungs, and life is restored. Initiated in the 1960s,<sup>15</sup> it is a successful technique in reviving patients from imminent death. Within a hospital setting, "code teams" of physicians and nurses are organized to respond to arrests. For out-of-hospital arrests, victims must depend on bystander participation in rescue breathing and CPR as well as quick responses by emergency medical services.<sup>16</sup>

The elements necessary for successful resuscitation include an early and quick response, initiation of bystander CPR, early defibrillation of ventricular arrhythmias,<sup>17</sup> and early advanced

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14. STEDMAN'S MEDICAL DICTIONARY 1534 (26th ed. 1995).

15. The first report showed a 70% survival rate among the 20 patients on which it was performed. Willem van Kouwenhoven et al., *Closed-Chest Cardiac Massage*, 173 JAMA 1064, 1064 (1960).

16. If spontaneous circulation does not return when advanced cardiac life support is administered by the paramedics, it is unlikely that the patient will be successfully resuscitated after being transported back to the hospital. Arthur L. Vellerman et al., *Predicting the Outcome of Unsuccessful Prehospital Advanced Cardiac Life Support*, 270 JAMA 1433, 1433 (1993).

17. Defibrillation of the ventricular arrhythmias directs a burst of electrical current at the erratically contracting cardiac muscle so that the electrical activity becomes organized and recruits the cardiac muscle into coordinated contractions and produces a forward flow of blood.

cardiac life support.<sup>18</sup> As an example, in a study of 3243 consecutive out-of-hospital cardiac arrests in New York City, overall survival was only 1.4%.<sup>19</sup> This was partly attributable to the lengthy response time and lack of bystander intervention.<sup>20</sup> To achieve survival and neurological recovery, basic life support consisting of CPR should be initiated within four minutes of arrest and more advanced techniques of cardiac support within eight minutes.<sup>21</sup> However, of those in-hospital patients who receive CPR, few—on average, fifteen percent—recover from their underlying illness to be ultimately discharged.<sup>22</sup> Hospitalized patients who are most likely to survive CPR are those with sudden cardiopulmonary collapse due to an acute cardiovascular illness, whereas those least likely to survive are patients with debilitating illness, widespread cancer, repeated arrests, and chronic illnesses.<sup>23</sup> Among patients who survived CPR but were not discharged from the hospital, the length of survival ranged from two to fourteen days.<sup>24</sup> This has prompted many studies about the efficacy of the application of CPR and has caused

18. Emergency Cardiac Care Committee and Subcommittees, Am. Heart Ass'n, *Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care*, 268 JAMA 2171, 2184 (1992) [hereinafter *Guidelines for CPR*].

19. Gary Lombardi et al., *Outcome of Out-of-Hospital Cardiac Arrest in New York City*, 271 JAMA 678, 678 (1994).

20. *Id.* at 680.

21. *Guidelines for CPR*, *supra* note 18, at 2184.

22. An early study from Denmark, at a time when coronary care units were first organized, showed a reasonable effectiveness of the resuscitative process for patients suffering a cardiac arrest both on the ward and in the unit. Thirty-eight of 161 patients (24%) survived to be discharged from the hospital. Bo Dupont et al., *The Long-Term Prognosis for Patients Resuscitated After Cardiac Arrest*, 78 AM. HEART J. 444, 445 (1969). At the Beth Israel Hospital in Boston, 30% of patients dying underwent CPR. Of 294 patients reported, 128 (44%) survived the resuscitation effort but only 41 (14%) were discharged from the hospital. Susanna E. Bedell et al., *Survival After Cardiopulmonary Resuscitation in the Hospital*, 309 NEW ENG. J. MED. 569, 569-70 (1983). A literature review of 42 publications revealed that of 12,961 patients resuscitated, CPR was initially successful in 38.5% of patients, but only 14.6% (range, 3% to 27%) were discharged from the hospital. Roland B. McGrath, *In-House Cardiopulmonary Resuscitation - After a Quarter of a Century*, 16 ANNALS EMERGENCY MED. 1365, 1365 (1987). A report from Sinai Hospital of Detroit states that out of 105 hospitalized patients who received CPR, 98 died during their hospitalization, four underwent coronary artery bypass grafting and survived, three died shortly after discharge, and one remained in a persistent vegetative state. Stephanie C. Warner & Tann K. Sharma, *Outcome of Cardiopulmonary Resuscitation and Predictors of Resuscitation Status in an Urban Community Teaching Hospital*, 27 RESUSCITATION 13, 13 (1994).

23. Alfred L. George, Jr. et al., *Pre-Arrest Morbidity and Other Correlates of Survival After In-Hospital Cardiopulmonary Arrest*, 87 AM. J. MED. 28, 32 (1989).

24. Leslie J. Blackhall, *Must We Always Use CPR?*, 317 NEW ENG. J. MED. 1281, 1283 (1987).

medical personnel to rethink its application in the hospital setting.<sup>25</sup> Many patients may choose to forgo CPR by consenting to a DNR order. This concept will be explained below in section III.

Of all the settings in the hospital, the operating room is the best place for the patient to be if there is a need for resuscitation because the environment is highly controlled. The equipment and technology needed to resuscitate a dying patient is available at the health care provider's fingertips. Teams of operating room personnel are available to act in unison to do everything humanly possible (within the realm of modern medical technology) to reverse the life-threatening event. The anesthesiologist is able to provide a secure airway, control a patient's breathing, and administer drugs to maintain circulation. The surgeon can perform CPR by closed-chest massage, or ultimately—in a manner not possible anywhere else in the hospital—the surgeon could place the patient on cardiopulmonary bypass to take over the work of the heart and lungs while simultaneously addressing the cause of the arrest, be it trauma, embolization, hemorrhage, or a primary cardiac event.

Given the principles of informed consent, discussed in the next section, the reality that the surgical ward is the best place to receive CPR, and the fact that the patient wanted and consented to the surgical procedure, the surgical team must know what to do with a DNR order during surgery.

## II. INFORMED CONSENT

### A. *The Legal and Ethical Foundations of Informed Consent*

In order to administer medical therapy to a patient, a physician must have the consent or permission of the patient for a particular intervention. The legal concept of consent for medi-

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25. There is a conflict between doing a procedure because technically it can be done (and justifying it by saying one cannot predict with certainty the outcome) and forgoing this procedure because it would simply prolong suffering, delay the dying process, and remove the patient's dignity in the dying moment. Maurice Fox & Helene Levens Lipton, *The Decision to Perform Cardiopulmonary Resuscitation*, 309 NEW ENG. J. MED. 607, 607 (1983).

For illnesses where CPR has been shown to be of no benefit (for example, metastatic cancer, acute stroke, sepsis, or pneumonia), some recommend that CPR should not be considered an option of medical therapy. Rather, it is suggested that a DNR order (written under the unilateral authority of the physician) should be accompanied by a note in the chart stating the condition for which CPR is futile and recommending that CPR not be performed. See, e.g., Blackhall, *supra* note 24, at 1282, 1284.

cal treatment evolved in this century under tort law.<sup>26</sup> Operating on a part of the body for which the patient did not give consent (expressed or implied) was unlawful and, therefore, constituted a battery.<sup>27</sup> Justice Cardozo is often quoted for providing the legal basis for consent: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."<sup>28</sup> The doctrine requires the physician or agent to disclose any information necessary for the patient to make a proper decision and to obtain a voluntary consent.

Courts of most states now recognize a lack of informed consent cause of action under the law of negligence for an abrogation of the duty.<sup>29</sup> In addition, all states have legislated minimum standards of disclosure that the medical profession must meet prior to performing invasive procedures.<sup>30</sup>

Informed consent is a well-established standard of medical ethics. The American Medical Association has, since its inception in 1847, maintained a code of ethics for its members.<sup>31</sup> The basic rights of patients are enunciated in the "Fundamental Elements of the Patient-Physician Relationship." In the opinion on informed consent, the AMA stated: "The physician's obligation is to present the medical facts accurately to the patient . . . [and] to make recommendations . . . to help the patient make choices from among the therapeutic alternatives . . . ."<sup>32</sup>

Through medical ethics principles and legal doctrine, informed consent has evolved into an informed decision-making process. In order to make a decision as to whether to consent to

26. Anthony Szczygiel, *Beyond Informed Consent*, 21 OHIO N.U. L. REV. 171, 184-85 (1994).

27. *Mohr v. Williams*, 104 N.W. 12, 14 (Minn. 1905) (noting that "the right to the inviolability of [the patient's] person" prohibits a surgeon, no matter how skilled or how successful the operation, from "violating" that person without consent).

28. *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

29. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir. 1972) ("The patient's right of self-decision shapes the boundaries of the duty to reveal . . . [and] can be effectively exercised only if the patient possesses enough information to enable an intelligent choice."). See also Jon F. Merz, *On a Decision-making Paradigm of Medical Informed Consent*, 14 J. LEGAL MED. 231, 232-33 (1993); Szczygiel, *supra* note 26, at 209-11.

30. See Szczygiel, *supra* note 26, at 190.

31. Nancy W. Dickey, *AMA Code of Medical Ethics a Link to Our Past*, AM. MED. NEWS, Mar. 24/31, 1997, at 21.

32. COUNCIL OF ETHICAL AND JUDICIAL AFFAIRS OF THE AM. MED. ASS'N, CODE OF MEDICAL ETHICS 120 (1997).



a particular form of therapy, the patient must be given sufficient information about the procedure, its risks and benefits, and the alternatives to the proposed therapy. The patient may then agree or refuse to proceed.

### B. Presumed Consent

Courts recognize an exception to obtaining an informed consent for bona fide emergency situations, where the life and health of the person must be preserved and consent could not be obtained in any fashion. It is permissible for, even the duty of, the surgeon to perform a life-saving emergency operation without consent.<sup>33</sup> Courts base this concept of implied or presumed consent on the theory that they do not wish any rule or principle of law to interfere with emergency treatment.<sup>34</sup> When faced with the threat of the loss of life or serious disability, it is presumed that any reasonable person would consent to proper medical therapy. If the patient is unconscious, if no family members are available to consult, or if the situation warrants an immediate response (for example, hemorrhage, respiratory cessation, or cardiac arrest), the physician has the *duty* to intervene responsibly at the level of acceptable medical practice.<sup>35</sup> It is important for the physician to document the nature of the emergency and the reason why consent cannot be obtained.<sup>36</sup>

### C. CPR by Presumed Consent

CPR is classified as an "emergency procedure" by hospitals and other medical institutions and is automatically instituted for any patient who suffers a cardiac arrest, regardless of the underlying disease.<sup>37</sup> This is performed on patients on the basis of presumed consent.<sup>38</sup> Consent is presumed because at the time

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33. This principle was founded in turn-of-the-century cases such as *Pratt v. Davis*, 79 N.E. 562, 565 (Ill. 1906), and *Mohr*, 104 N.W. at 15.

34. *Schloendorff*, 105 N.E. at 93; see also *Mohr*, 104 N.W. at 15 (Minn. 1905); *Tabor v. Scobee*, 254 S.W.2d 474, 476 (Ky. 1952) (surgeon's removal of Fallopian tubes without consent actionable because not under emergency circumstances); RESTATEMENT (SECOND) OF TORTS § 892D (1979).

35. *Schloendorff*, 105 N.E. at 93; see also *Pratt*, 79 N.E. at 565; *Luka v. Lowrie*, 136 N.W. 1106, 1110 (Mich. 1912); *Jackovach v. Yocom*, 237 N.W. 444, 449-50 (Iowa 1931).

36. Emidio A. Bianco & Harold L. Hirsh, *Consent to and Refusal of Medical Treatment*, in LEGAL MEDICINE 274, 283-84 (American College of Legal Medicine ed., 1995).

37. Blackhall, *supra* note 24, at 1282-83.

38. Kathleen M. Boozang, *Death Wish: Resuscitating Self-Determination for the Critically Ill*, 35 ARIZ. L. REV. 23, 25 (1993).

of arrest, the patient is incapable of giving informed consent and the lack of initiating immediate treatment will result in severe neurological damage and death.<sup>39</sup> It is also the legal responsibility of physicians and nurses who are on duty to institute CPR when medically indicated unless a contrary order is given.<sup>40</sup> CPR is the only medical intervention that can be performed by a nonphysician without a physician's order.

There are two exceptions to the institution of CPR on the basis of presumed consent.<sup>41</sup> First, patients may positively influence their hospital course by denying permission to administer CPR in the event of cardiac arrest by way of an advance directive or recorded discussions with medical personnel.<sup>42</sup> For example, a terminally ill patient may refuse CPR, in which case the physician enters a DNR order, as explained below. Patients need to discuss options early in their medical course. If the patient is unable or incapable of making a decision, the family or surrogate may make this decision.<sup>43</sup>

Second, the medical profession recognizes that there are instances when initiating resuscitation would be inappropriate. Specifically, resuscitation might be inappropriate if the treatment would have "no medical benefit" (in other words, it would be futile), if the quality of life after CPR would be poor, or if the quality of life before resuscitation is already poor.<sup>44</sup> Treatment would be futile, for example, if the patient had metastatic carcinoma *and* further medical therapy would not provide any physi-

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39. Peter J.F. Baskett, *Ethics in Cardiopulmonary Resuscitation*, RESUSCITATION, Feb. 1993, at 1, 2.

40. *Id.* at 4.

41. Council on Ethical and Judicial Affairs, Am. Med. Ass'n, *Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders*, 265 JAMA 1868, 1868 (1991).

42. *Id.* See, e.g., Illinois Living Will Act, 755 ILL. COMP. STAT. ANN. 30/1 (West 1997).

43. Jerry A. Menikoff et al., *Beyond Advance Directives - Health Care Surrogate Laws*, 327 NEW ENG. J. MED. 1165, 1165 (1992). See generally Stephen M. Fatum et al., *A Review of the Illinois Health Care Surrogate Act*, 80 ILL. B.J. 124 (1992) (discussing the background and specific provisions of the Illinois statute).

44. Paul Goulden, *Non-Treatment Orders, Including Do Not Resuscitate (DNR)*, in PRINCIPLES OF HEALTH CARE ETHICS, 734-35 (Raanan Gillon ed., 1994). See also Keith Shiner, Note, *Medical Futility: A Futile Concept?*, 53 WASH. & LEE L. REV. 803, 838-39 (1996); George J. Annas, *The "Right to Die" in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 DUQ. L. REV. 875, 887-88 (1996).

ologic improvement.<sup>45</sup> There are a variety of views on the issue of futility.<sup>46</sup>

### III. "DO NOT RESUSCITATE" ORDERS

Given that presumed consent for CPR of hospitalized patients leads to nearly indiscriminate and universal use of the procedure, hospitals have recognized instances when a patient may request a DNR order.<sup>47</sup> DNR orders are appropriate only for the terminally ill patient, in other words, one who is facing imminent death.<sup>48</sup> The courts, legislatures, and medical profession have all recognized the value of DNR orders and patient autonomy in deciding when to forgo resuscitation.

In the leading case of *In re Dinnerstein*,<sup>49</sup> the court determined that a physician may enter such an order without the permission of the court. In that case, the family of an incompetent patient in a vegetative state pleaded with the court to allow an order to be entered not to resuscitate the patient should an arrest occur. The court recognized that the patient's prognosis was hopeless—"that death must come soon"—and any attempt at resuscitating the patient would not relieve the illness.<sup>50</sup> There was no life-prolonging therapy available. The court concluded that the decision of the appropriate therapy for the patient to ease her out of her terminal illness was best addressed by her attending physician, not by the courts. Judicial review should be performed only if there is a question of whether the medical practitioner acted at the level of the standard of care.<sup>51</sup>

On December 1, 1991, the concept of self-determination in health care was codified in the Patient Self-Determination Act,<sup>52</sup> requiring hospitals and other health care providers participating in the Medicare and Medicaid programs to give patients infor-

45. Bernard Lo, *Unanswered Questions About DNR Orders*, 265 JAMA 1874, 1874 (1991).

46. See, e.g., Shiner, *supra* note 44; Giles R. Scofield, *Medical Futility Judgments: Discriminating or Discriminatory?*, 25 SETON HALL L. REV. 927 (1995).

47. See, e.g., LUMC DNR Policy, *supra* note 11.

48. Mary Ellen Rosen, *The Do Not Resuscitate Policy: Jurisdiction Over Policy and the Therapeutic Privileges*, 4 HEALTH LAW. 3, 3 (1990).

49. 380 N.E.2d 134 (Mass. App. Ct. 1978).

50. *Id.* at 138-39.

51. *Id.* at 139.

52. The Patient Self-Determination Act, Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206 & 4751, 104 Stat. 1388-115 & 1388-204 (1991) (codified in scattered sections of 42 U.S.C., especially §§ 1395cc(f) & 1396a(w) (1995)).

mation explaining their legal options for refusing or accepting treatment should they become incapacitated.

Over the past decade, ethicists, physicians, and commissions have provided guidelines to assist hospitals in developing and changing policies that address the concept of DNR. In general, these guidelines have the following principles in common:

- (1) DNR orders should be documented in the written medical record.
- (2) DNR orders should specify the exact nature of the treatment to be withheld.
- (3) Patients, when they are able, and families should participate in DNR decisions. Their involvement and wishes should be documented in the medical record.
- (4) Decisions to withhold CPR should be discussed with other staff, including nurses.
- (5) DNR status should be reviewed on a regular basis.
- (6) DNR is not equivalent to medical or psychological abandonment of patients.<sup>53</sup>

In 1988, the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") required hospitals to develop a policy on the withholding of resuscitative services from patients and has incorporated the above six guidelines into its accreditation standards.<sup>54</sup>

Thus, this country has evolved into a nation that allows patients or their surrogates to make decisions regarding therapeutic alternatives, including the withholding of resuscitation.

#### IV. CPR IN THE OPERATING ROOM

An area of the hospital where adhering to a DNR order may be confusing is the operating room. Whether to rescind or honor the DNR order during surgery is widely debated among ethicists and medical personnel.<sup>55</sup> In a study at a teaching hospi-

53. Stuart J. Youngner, *Do-Not-Resuscitate Orders: No Longer Secret, But Still a Problem*, 17 HASTINGS CENTER REP. 24, 25 (1987).

54. THE JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., 2 ACCREDITATION MANUAL FOR HOSPITALS, RI.1.2.6 & RI.1.2.7, 84-85 (1995).

55. Cynthia B. Cohen & Peter J. Cohen, *Do-Not-Resuscitate Orders in the Operating Room*, 325 NEW ENG. J. MED. 1879, 1880 (1991) [hereinafter Cohen & Cohen, *DNR Orders*]; Robert D. Truog, "*Do Not Resuscitate*" Orders During Anesthesia and Surgery, 74 ANESTHESIOLOGY 606, 606 (1991) [hereinafter Truog, *DNR Orders*]; Robert M. Walker, *DNR in the OR: Resuscitation as an Operative Risk*, 266 JAMA 2407, 2407 (1991); Stuart J. Youngner et al., *DNR in the Operating Room: Not Really a Paradox*, 266 JAMA 2433, 2433 (1991) [hereinafter Youngner, *DNR in the Operating Room*]; see also Letter from Cory Franklin, Chicago Medical School, & David M. Rothenberg, Rush-Presbyterian-St. Luke's Medical Center, to the *New England Jour-*

tal, fifteen percent of patients with DNR orders underwent a surgical procedure.<sup>56</sup> Thus, it is not uncommon for the surgical team to face this issue.

A patient with a DNR order in the operating room seems a paradoxical situation.<sup>57</sup> If one is not going to perform basic life-saving therapy such as CPR (which has a great chance of success in the operating room) because of the terminal condition of the patient or because of the perceived futility of the treatment, then why should that patient undergo *any* surgical procedure that may be meant to cure a potentially life-threatening condition or improve the quality of the patient's dying days? The answer is clear: A terminally ill patient's decision to refuse resuscitation is not a decision to refuse palliative surgical procedures that have the opportunity to relieve pain, alleviate a correctable problem, or improve the quality of life with or without prolonging life. "Do not resuscitate" does not mean "do not treat."<sup>58</sup> A physician must attempt to provide care and comfort to the terminally ill patient. If a condition exists that could be corrected or palliated by surgery, then this form of therapy should not be denied a patient merely because the patient wishes no CPR. For example, a patient with a fatal type of cancer who develops an intestinal obstruction could undergo a surgical procedure to provide relief and prevent the horrible sequelae and suffering that would result from allowing the intestinal obstruction to run its natural course. A terminally ill cancer patient suffering intractable pain due to a tumor impinging on the spinal cord could benefit from surgery to alleviate this pain. A patient with terminal cancer with a tumor obstructing the esophagus could have a tube placed through the tumor, receiving palliation that allows the patient to swallow food and handle oral secretions. Other simpler procedures, such as a tracheostomy, gastrostomy, or insertion of a central venous line for infusion of fluids and drugs (especially analgesics), are all meant to increase patient comfort, provide good nursing care, and alleviate suffering. Each surgical procedure and each anes-

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*nal of Medicine* on DNR orders in the operating room, 326 *NEW ENG. J. MED.* 1571, 1571 (June 4, 1992); Letter from Charles Couper, Children's Hospital, to the *Journal of the American Medical Association* on DNR orders in the operating room, 267 *JAMA* 1465, 1465 (Mar. 18, 1992).

56. See Truog, *DNR Orders*, *supra* note 55, at 606.

57. Youngner, *DNR in the Operating Room*, *supra* note 55, at 2433.

58. Baskett, *supra* note 39, at 2.

thetic administration carries with it a risk.<sup>59</sup> The patient must determine if the potential benefits of the surgical procedure to better the quality of life are worth the risks of the intervention. The ultimate risk, of course, is dying during or as a result of the intervention.

As explained above, by definition, a patient with a DNR order has a terminal illness—death is imminent. The patient, or surrogate, has determined that there is no need to prolong the dying process by means of resuscitation should a cardiac arrest occur.<sup>60</sup> However, in the operating room, it is important to understand the difference between a cardiac arrest that has occurred as a result of an anesthetic or surgical act (or misadventure) and one that has occurred as a result of the disease process that is the cause of the terminal illness.<sup>61</sup> If the arrest is caused by the disease process, then the presence of the patient in the operating room is no different from the patient's presence on the ward, and therefore it would be appropriate to honor the DNR order and forgo resuscitation efforts. Quite to the contrary, and particularly important to the issue, an arrest resulting from the *surgical* procedure, if properly attended to, will likely not cause an untoward result. Thus, if an arrest occurs in the operating room as a result of the anesthetic or surgical intervention, resuscitation could be performed with success and the patient may suffer no adverse effect.<sup>62</sup>

To illustrate, if a patient bleeds massively because a tumor related to the underlying illness eroded into a major vessel, the terminal condition caused the patient's bleeding. However, if the patient bleeds massively during a surgical exploration because the surgeon inadvertently severed a major blood vessel, it is an iatrogenic complication and not the disease process that caused the bleeding, and the surgeon has a fiduciary obligation to do everything possible to stabilize the patient by repairing the injury and, if necessary, resuscitating the patient. Of course, a policy that requires a surgeon to pick and choose when to resuscitate is unacceptable.

As explained above, the surgical ward is the environment in which CPR can be performed most successfully. The operating room is not an arena where personnel stand by idly and allow a

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59. Walker, *supra* note 55, at 2408.

60. Cohen & Cohen, *DNR Orders*, *supra* note 55, at 1881.

61. *Id.* at 1880.

62. Truog, *DNR Orders*, *supra* note 55, at 607.

patient to die. By the very nature of their training and everyday activity, surgeons and anesthesiologists are aggressive interventionists who always attempt to resuscitate the dying patient. Surgeons face daily critical situations where quick and decisive action is required. In surgery, there may not be the luxury of time to cerebrated about a problem, discuss it with one's colleagues, or research it thoroughly. Decisions have to be made quickly in response to the situation presented. If a patient is bleeding, the surgeon controls the bleeding; if a patient has low blood pressure, the anesthesiologist administers fluids and drugs; if a patient goes into cardiac arrest, the team resuscitates immediately. No one would want the surgeon, anesthesiologist, or team to waste valuable moments deciding *whether* to respond.

Another issue arises from the very nature of anesthesia for surgery. Anesthesia involves the deliberate depression and then resuscitation and stabilization of vital signs. The anesthesiologist puts a patient to sleep by administering potent drugs that reduce consciousness and paralyze the breathing mechanism. This is followed by assisted ventilation and then placement of an endotracheal tube for a secured airway. A drop in blood pressure caused by the anesthetic may require stabilization by the use of vasoactive drugs and fluids. All of these steps are routine during an operation. But, performed under other circumstances, such as cardiac arrest, these steps are the very components of resuscitation. Short of cardiac compressions and countershock, anesthetic management is the same as cardiopulmonary resuscitation. In the operating room, these interventions are needed to maintain homeostasis (that is, equilibrium of physiologic functions), and should not be viewed as resuscitation.<sup>63</sup> However, once cardiac arrest has occurred, all interventions are considered rescue responses.

Since there can be no easy, logical, or mechanical response to the issue of whether to resuscitate in surgery a patient with a DNR order, hospitals must institute appropriate policies.

## V. DNR POLICY IN THE OPERATING ROOM

It is imperative that surgeons, nurses, and other health care providers know what to do in the operating room. Without hospital guidance, ethical and legal dilemmas will arise. For exam-

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63. Youngner, *DNR in the Operating Room*, *supra* note 55, at 2434.

ple, if required to follow a DNR order in the operating room, surgeons and anesthesiologists should only be expected to forgo resuscitation, not the maintenance of homeostasis.<sup>64</sup> But even this seemingly logical and straightforward principle can cause confusion as maintaining homeostasis consists of many of the same actions as resuscitation. In addition, an ethical dilemma will arise among operating room personnel who may feel that their inactivity or failure to treat may be directly responsible for a patient's death.<sup>65</sup> Patients are not sent to the operating room to die, and surgeons, anesthesiologists, and nurses have a responsibility to prevent the patient's demise.<sup>66</sup> Likewise, death in the operating room is looked upon as a "bad outcome" and may adversely affect the psychology of the surgeon and operating room personnel who are responsible for what happens to the patient in the operating room.<sup>67</sup> Operating room personnel are uncomfortable with allowing a patient to die during an operative procedure because of a DNR order.<sup>68</sup>

Unfortunately, not all hospitals have policies identifying how to deal with a patient with a DNR order who is in the operating room.<sup>69</sup>

When the patient enters the operating room, there are three courses of action that may be taken as a matter of philosophical and ethical approach, or as a matter of policy:

- (1) automatic suspension of DNR orders,<sup>70</sup>
- (2) strict adherence to the DNR status,<sup>71</sup> or
- (3) "required reconsideration" of DNR orders.<sup>72</sup>

Each of these options is discussed below.

### A. *Automatic Suspension of DNR Orders*

Some hospitals automatically suspend DNR orders when patients enter operating rooms and then reinstate the orders upon the patients' return to post-recovery rooms. There are several

64. Cohen & Cohen, *DNR Orders*, *supra* note 55, at 1880.

65. *Id.* at 1881.

66. Walker, *supra* note 55, at 2408.

67. *Id.*

68. Cohen & Cohen, *DNR Orders*, *supra* note 55, at 1881; Youngner, *DNR in the Operating Room*, *supra* note 55, at 2434.

69. See LUMC DNR Policy, *supra* note 11; Truog, *DNR Orders*, *supra* note 55.

70. *Id.*; Walker, *supra* note 55, at 2407. See, e.g., Alexian Brothers DNR Policy, *supra* note 13.

71. Walker, *supra* note 55, at 2407.

72. Cohen & Cohen, *DNR Orders*, *supra* note 55, at 1880.



reasons why an automatic suspension of DNR orders in the operating room could be an appropriate policy.

First, the patient who requests and consents to a surgical procedure agrees to a series of interventions, such as the administration of an anesthetic, controlled ventilation, and the use of vasoactive drugs, during the surgical procedure itself, which are, as stated above, routine procedures for anyone undergoing surgery necessary to maintain homeostatic stability; yet they are also components of resuscitation. Arguably, a consent for surgery, therefore, is a consent for "resuscitation," which contravenes the DNR order.

Second, there is a difference between a cardiopulmonary arrest that occurs spontaneously (for example, from a myocardial infarction, shock, cerebrovascular accident, or trauma) outside the operating room and one that occurs as a result of a therapeutic intervention in the operating room (for example, esophageal intubation, pneumothorax, drug overdose, or severance of a blood vessel). There is a greater chance of successful resuscitation with the latter than with the former incident. In the operating room, an arrest that occurs during anesthesia could be considered a result of surgical intervention and should be reversible. The premise is that if cardiac arrest occurs during or as a result of anesthesia, is immediately recognized, and is properly treated, CPR is highly successful. In the surgical environment, resuscitation or CPR would help the patient to achieve the original objective in undergoing the surgical procedure and with minimal risk of an untoward effect.

While patients may fear that inappropriate CPR could result in a chronic vegetative state or prolonged intensive care, timely and successful CPR to recover from cardiac arrest as a result of anesthesia can actually prevent serious neurological damage.<sup>73</sup>

Third, each anesthetic agent causes hemodynamic instability. The more unstable a patient, the lighter the anesthetic used to minimize precarious hemodynamics. Vasoactive drugs (that is, those directly affecting the heart and blood vessels) are used to keep the patient physiologically stable. With a DNR order in place during surgery, the patient would not be able to benefit fully from the analgesic effect because the use would be very conservative to keep the patient as stable as possible.<sup>74</sup>

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73. See Truog, *DNR Orders*, *supra* note 55, at 607.

74. *Id.*

The obvious drawback of automatically suspending the DNR order during surgery is that it is inconsistent with the patient's wishes. However, patients should be told of the policy when providing consent for the surgical procedure. The hospital's policy must clearly identify when the DNR order is suspended and when it is reinstated (for example, after the patient leaves the post-recovery room).

### B. *Strict Adherence to the DNR Status*

The second approach to dealing with the patient with a DNR order while in the operating room is strictly adhering to this order. A patient's rights, including the right to refuse resuscitation, do not end at the operating room door. Automatic suspension of a DNR order denies the patient the right of self-determination, which entitles the patient to reject or request resuscitation. Strict adherence to the patient's right of self-determination requires the surgical team to follow the DNR order unless it is rescinded by the patient or the patient's representative. Refusal of the patient's directive may not be legal in view of this act.<sup>75</sup> Therefore, an argument may be made to strictly adhere to the request of DNR when the patient goes to the operating room for surgical intervention.

The negative implications of such a policy are clear as explained above—maintenance of homeostasis can be compromised, the surgical team may protest, and the positive results of the consented-to surgery can be lost.

### C. *"Required Reconsideration" of DNR Orders*

Blending the concepts discussed above—permitting the normal conduct of a surgical procedure and allowing for the expression of the patient's right—is the goal of the policy of "required reconsideration."<sup>76</sup> As explained by the Association of Operating Room Nurses, this policy "allows a patient or surrogate to participate in decisions about the use of cardiopulmonary resuscitation . . . [and] offers caregivers an opportunity to explain the

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75. See Vicki Joiner Bowers, *Advance Directives: Peace of Mind or False Security?*, 26 STETSON L. REV. 677, 721 (1996); The American Society of Anesthesiologists, Inc., Abstract, G. Boyd & A. Boudreaux, *DNR Orders in the Operating Room: A Survey of Anaesthesiologists' Opinions and Concerns*, 75 ANESTHESIOLOGY A900 (1991).

76. Cynthia B. Cohen & Peter J. Cohen, *Required Reconsideration of "Do-Not-Resuscitate" Orders in the Operating Room and Certain Other Treatment Settings*, 20 LAW MED. & HEALTH CARE 354, 354 (1992) [hereinafter Cohen & Cohen, *Required Reconsideration*].

significance of cardiac arrest and resuscitation in the perioperative setting.”<sup>77</sup> It is the responsibility of the primary physician and the surgeon to discuss with the patient or surrogate the details of the operation, its potential dangers, the types of therapy that are usual during surgery, and the reasons for suspending a DNR order during this period. The patient or surrogate will then be able to make a decision of how to proceed. In this way, the patient’s right of self-determination is respected and the surgical team knows exactly how to proceed.

The results of this decision must be documented in the patient’s medical chart and the information shared with all members of the health care team. If any member of the team is uncomfortable with the patient’s decision—whether to resuscitate or not during the surgical procedure—an alternative member should be sought, but the expressed wishes of the patient must be honored.

Certainly, this third option addresses the concerns of everyone involved. However, it does not solve the problems raised above for the patient who wishes to keep the DNR order standing during surgery.

Regardless of the position adopted by the hospital, it is imperative that the hospital establish and articulate its policy.

### CONCLUSION

Informed consent is the best process by which physicians fulfill their fiduciary responsibility to their patients. Pursuant to the Patient Self-Determination Act, hospitals must now provide patients with information about advance directives. Through this vehicle, patients may discuss and document their wishes regarding the direction of therapy their providers should take under circumstances when the patient is terminally ill or incapacitated. Unless otherwise directed, by virtue of presumed consent, the hospital’s health care providers will automatically resuscitate the hospitalized patient, should such action be neces-

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77. Jackie L. Hamblet et al., *Proposed AORN Position Statement on Perioperative Care of Patients With Do-Not-Resuscitate (DNR) Orders*, 61 AORN J. 60, 60 (1995). The American College of Surgeons has adopted this position. Statement of the American College of Surgeons on Advance Directives by Patients, “Do Not Resuscitate” in the Operating Room, 79 AM. C. SURGEONS BULL. 29 (1994); American Society of Anesthesiologists, *Ethical Guidelines for the Anesthesia Care of Patients With Do-Not-Resuscitate Orders or Other Directives That Limit Treatment* (Oct. 13, 1993) (on file with the *Annals of Health Law*).

sary. When a patient or surrogate decides to forgo these resuscitative efforts, a DNR order is entered.

This does not imply that a terminally ill patient receives no care or less care. If an operative intervention is undertaken to alleviate pain and suffering, that procedure may alter the patient's homeostasis enough that some form of resuscitation—even CPR—would be necessary. Since the surgeon's goal is not to harm the patient, and the operative intervention should not hasten the patient's death, resuscitation should be permitted during the perioperative period, as is the standard of care for all patients. However, patient autonomy must be respected.

To strictly adhere to a DNR order in the operating room would be contrary to the goal of surgery and the surgical team's obligations. To automatically suspend a DNR order upon entry into the operating room is a paternalistic infringement on the patient's right of self-determination. "Required reconsideration," however, addresses most concerns and allows for a thoughtful solution to a complex problem with time on everyone's side.<sup>78</sup> It allows the physician to follow the Hippocratic oath and it gives the patient the opportunity to choose the extent of the treatment and thereby maintain dignity and autonomy.

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78. Cohen & Cohen, *Required Reconsideration*, *supra* note 76.