

Anesthesiology
76:865, 1992

The Meaning of Do-not-resuscitate during Anesthesia

To the Editor:—I disagree with the position taken by Truog¹ suggesting that "do-not-resuscitate" (DNR) orders apply to the use of life support systems for short-term therapeutic as well as long-term situations. A DNR order for a competent autonomous patient with a clear advance directive says, "When I am dying of my disease, please do not interfere with the dying process." It does not say "I do not want life-saving help under any circumstances." When this patient undergoes surgery that requires anesthesia, the DNR order applies with regard to unpreventable death from the patient's disease or condition but does not apply to treatment of iatrogenic factors or other reversible conditions that may lead to cardiorespiratory arrest. The preanesthetic conference must include careful differentiation between interventions performed to resuscitate or support the patient from effects of the anesthesia and the surgery and those carried out to delay "death as a result of the disease." In my discussion with patients and their families, we often agree that postoperative ventilatory support may be necessary to help the patient recover from the procedure. They understand that this is different from being ventilator-dependent.

We then discuss the options if the patient cannot successfully resume spontaneous ventilation. The same distinction is made for other supportive techniques. If the anesthesiologist, the surgeon, and the patient clearly understand the difference between unpreventable death from a disease for which there is no further successful treatment and resus-

citation from other causes of cardiorespiratory arrest, the patient's wishes can be respected and the physicians' ethical standards can be maintained.

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REFERENCE

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The opinion expressed in this letter is that of the author and does not represent the position of the Department of Veteran Affairs or that of the University of Missouri.

(Accepted for publication January 31, 1992.)

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In Reply:—Braunschweig's claim that a "do-not-resuscitate" (DNR) order "applies with regard to unpreventable death from the patient's disease or condition but does not apply to treatment of iatrogenic factors or other reversible conditions that may lead to cardiorespiratory arrest" is simply mistaken. Patients clearly have the right to refuse resuscitation even when death is preventable and the cause is reversible.¹ Furthermore, whether the event is iatrogenic is irrelevant from the patient's point of view.

For the reasons that Braunschweig cites, however, most patients will choose to have their DNR order suspended during anesthesia and surgery, since in most cases this will be in their best interest. That most patients will consent to suspension of their DNR order does not allow us to ignore the process of consent, nor does it allow us to impose our opinion upon patients who do not share our view. For example, even though most patients with appendicitis will choose to have an appendectomy, we are nevertheless obligated (both morally and legally) to seek the patients' consent and abide by their decision.

Clearly, a patient cannot simultaneously request a general anesthetic and refuse to give permission for procedures that are intrinsic to anesthetic care. In my view, artificial ventilation and the administration of fluids and medications are intrinsic to the delivery of a general anesthetic, whereas chest compressions are not. Some patients may therefore reasonably insist on maintaining their DNR status with regard to chest compressions during anesthesia and surgery. Recent surveys show that whereas some anesthesiologists are opposed to administering anesthesia under these conditions, others are willing.² Hospital policy should therefore be flexible to respond to the concerns of everyone

involved. This conclusion is shared by other commentators on the issue.^{3,4}

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(Accepted for publication January 31, 1992.)