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Advance directives and surgery: Clinical report provides guidance

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Is it possible to approach surgery or anesthesia in a child or adolescent with a Do-Not-Attempt-Resuscitation (DNAR) order short of summarily cancelling the order?

An updated AAP clinical report can help medical teams understand that they should not cancel a DNAR order without a family discussion, as this does not respect the important decisions that the family or an age-appropriate child has made.

The report, *Interpretation of Do-Not-Attempt-Resuscitation Orders for Children Requiring Anesthesia and Surgery*, from the Sections on Surgery and Anesthesia and the Committee on Bioethics, is available at https://doi.org/10.1542/peds.2018-0598 and will be published in the May issue of *Pediatrics*.

Honoring goals of care

Both DNAR and DNR (Do Not Resuscitate) terms imply that resuscitation will be "omitted" or not done. Sometimes, this can be misinterpreted as "giving up." Because of this, some have advocated for the term "allow natural death," to emphasize ongoing comfort or end-of-life care. In other words, the medical team continues to care for the child, but the goals of care are different.

DNAR in and of itself is not particularly controversial for appropriate children, as much as it is a difficult decision to make for all concerned. It requires shifting the focus from doing everything possible to save a child to doing everything to make the end of life as comfortable as possible, with as much quality and dignity as possible. The physician or the family might first recognize that striving for curative care is no longer beneficial, but the entire treatment team eventually needs to embrace this concept for it to be successful. This is the ultimate in patient- and family-centered care.

"Required reconsideration" is the accepted practice of discussing a pre-existing DNAR order with the patient, family and medical team in preparation for deciding how to put this in context during a surgical procedure. The choices are to cancel the DNAR order or to honor it by providing a goal- or a procedure-directed approach.

The aim of a goal-directed approach is to do everything to prevent the need for resuscitation. If resuscitation is needed, this approach recognizes that patients are more concerned with preservation of pre-existing quality of life. This model honors the family's treatment goals while reflecting the reality and unique aspects of the operating room, but it requires a pre-existing relationship with the family.

A procedure-directed approach involves careful consideration of a series of specific interventions (a checklist) that might be used in the operating room. The checklist is similar to what might be considered for limits of resuscitation. Each procedure must be placed in the context of the child's usual quality of life and likelihood of the ability of the procedure to produce the desired effect. This approach has limited flexibility when an unexpected situation occurs.

In the operating room, many of the techniques and agents used can routinely promote cardiovascular instability and respiratory depression, which makes the discussion of resuscitation choices for a patient with a pre-existing DNAR order more complex and challenging. Many DNAR orders include clauses requesting that children not be intubated in the setting of respiratory arrest. As part of routine anesthetic care even for certain minor procedures, children are commonly intubated and placed on mechanical ventilation.

It is imperative that the physiologic changes that occur with anesthesia are thoroughly explained to the patient and family, and the possibility of post-operative mechanical ventilation is addressed.

Hospitals are encouraged to develop and maintain written policies permitting the foregoing of life-sustaining treatment of patients, including children and adolescents, in appropriate circumstances. Once a DNAR order is in place according to accepted standards, it is important that it is reviewed with the patient and/or caregiver before surgery to determine applicability in the operating room and the postoperative recovery period.

Dr. Fallat is a lead author of the clinical report and a member of the AAP Section on Surgery Executive Committee. She is a former chair of the Committee on Bioethics.

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