Decision-Making Regarding CPR in Older Surgical Patients: Time for a New Approach

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ASA guidelines for perioperative management of do-not-resuscitate (DNR) orders recommend that we revisit existing DNR orders prior to surgery and modify them as needed to align with patient preferences and clinical circumstances (asamonitor.pub/3lq2qgi). This “revisit and revise” or “required reconsideration” approach is a clear step beyond “automatic reversal” of DNR orders in that it preserves patients’ rights to self-determination and promotes patient-centered decision-making (Anesthesiology 1991;74:606-8).

These guidelines are silent, however, regarding the vast majority of patients who present for surgery without DNR orders in place, and it is generally assumed that such patients desire to be “full code.” The aging of the United States population, a heightened understanding of age-related vulnerabilities, and a growing focus on goal-concordant care suggest it is time to revisit this approach to decision-making regarding CPR in the perioperative setting (Anesthesiology 2021;135:781-7). Our committee for ethics in challenging times advocates that the decision to engage a patient in CPR be based on the quality of available evidence and not the quantity of time spent in the perioperative setting (asamonitor.org/monitor/article-pdf/86/2/23/531370/20220200.0-00017.pdf).

In a recent issue of Anesthesiology, we and a team of authors spanning anesthesia, surgery, critical care medicine, geriatrics, law, and palliative care articulate an expanded approach to decision-making regarding CPR in older surgical patients (Anesthesiology 2021;135:781-7). We argue that the decision to engage a patient about their preferences should not hinge on whether a patient has a DNR order or other directive limiting treatment in place; like other elements of compassionate, ethical care, it should be tailored to the characteristics, circumstances, and preferences of the individual patient.

We propose an expanded approach to decision-making regarding perioperative CPR in older surgical patients based not on existing or presumed code status, but on patient-specific preferences and vulnerabilities. When caring for patients 75 years of age or greater, anesthesiologists should be attuned to documentation or evidence of conditions that indicate vulnerability to complications and poor outcomes after CPR, including age 85 or greater, ASA Physical Status IV or greater, diminished physiologic reserves predisposing to worse outcomes in a variety of settings (Anesthesiol 2020;130:1450-60).

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A s of November 24, 2021, there have been 47,916,623 total cases of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and 773,779 deaths in the United States (asamonitor.pub/3vkk36f). Vaccination can potentially halt spread of the virus, prevent severe disease in individuals who develop breakthrough infections, and permit the return to normal economic and social life (JAMA 2021;325:532-3; asamonitor.pub/3zPLRB). The Food and Drug Administration has authorized three COVID-19 vaccines for administration under emergency use authorization (EUA): Pfizer-BioNTech, Moderna, and Janssen (Johnson & Johnson) (asamonitor.pub/3a65pE).

Since late March 2021, the B.1.617.2 (Delta) variant of the SARS-CoV-2 virus has become the dominant variant globally (asamonitor.pub/3yZPLRB). It is more contagious, causing a surge in new COVID-19 infections, hospitalizations, and deaths, particularly among unvaccinated individuals (asamonitor.pub/3yZPLRB; J Travel Med 2021;28:taab124; J Travel Med 2020;27:taau021). Estimates of vaccine efficacy against the Delta variant vary. One study found the Pfizer-BioNTech vaccine to be 88.0% effective in preventing Delta variant infection after two doses, compared to 93.7% in preventing Delta variant vary. One study found the Pfizer-BioNTech vaccine to be 88.0% effective in preventing Delta variant infection after two doses, compared to 93.7% in preventing Delta variant infection after two doses, compared to 93.7% in preventing Delta variant infection after two doses (asamonitor.pub/3xxMw40). To date, over 454 million total vaccine doses have been administered in the U.S. (asamonitor.pub/3CZSxhr). Common side effects are mild and transient (e.g., injection site pain, fatigue, headache, muscle and joint pain, fever, nausea, vomiting, and lymphadenopathy). Severe side effects like anaphylaxis are extremely rare. Although all vaccines authorized under EUA are new, the likelihood of long-term side effects is extremely low (asamonitor.pub/3D3yqV; asamonitor.pub/3o5F50N). Despite the documented safety, efficacy, and widespread availability of COVID-19 vaccines in the U.S., only 62.8% of the eligible population is fully vaccinated as of November 24, 2021 (asamonitor.pub/3CZSxhr). In response to low vaccination rates but an increasing rate of infections and deaths, federal and state governments, health care systems, school districts, and private companies are instituting vaccine mandates. In this article, we will explore some ethical issues involved in vaccine mandates.

Ethical arguments supporting vaccine mandates

Traditional medical ethics focuses solely on the individual's health with little or no interference (e.g., resource rationing) using the four ethical principles characterized by Beauchamp and Childress: autonomy (respect for individual choice), beneficence (doing good), non-maleficence (avoiding harm), and justice (fairness) (Principles of Biomedical Ethics. 8th edition, 2019). However, public health ethics involves protecting community well-being. Therefore, traditional ethical frameworks are not appropriate for justifying public health initiatives (Public Health Reviews 2012;34:1-20). Community-level directives require an authority to force all members to act according to the public health initiative. The authority to coerce individuals to act in specific ways is clarified by J.S. Mill, “The only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others” (On Liberty and Utilitarianism. 1993). In such a situation, the authority (e.g., government) can mandate through policy, regulation, or law that all citizens, even against their individual choice, must follow the public health initiative to prevent harm to others. For example, the police can forcibly lock a citizen into a sanitarium to prevent him/her from actively spreading tuberculosis in the community.

Public health ethics focuses on collective beneficence, nonmaleficence, and justice over individual autonomy. Justice in society involves fairly distributing benefits and burdens among people. One of several theories of justice (e.g., utilitarianism, libertarianism, communitarianism, egalitarianism, etc.) is applied to deter-