Role of the Anesthesiologist in Advance Care Planning

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In 2017 a large Delphi panel defined advance care planning as “a process that supports adults at any age or stage of health in understanding and sharing their personal values, lifegoals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness." [1] Practically, advance care planning includes the identification and documentation of the legal alternate decision maker of the patient, and goals of care for patients with limited expectancy of life. The legal alternate decision maker is based on the hierarchy by state law. Advance directives are legally binding documents that allow individuals to exercise medical autonomy if deemed incapacitated. This is commonly in the form of a healthcare power of attorney (also called healthcare proxy) and living will. A systematic review published in 2017 found that 36.7% of US adults completed an advance directive document. [2] Prevalence of advance directives is higher in older age, higher education and income, and less frequent among non-white responders. [3] Advance care planning has evolved overtime, shifting from the emphasis on only legal documents to the importance of goals of care conversations documentation for seriously ill patients. The prevalence of advance care planning has been increasing over time. However, disparities are also seen with a prevalence of only 20% of advance care planning among racial and ethnic minorities, with limited health literacy, LGBTQIA, homeless and incarcerated populations. [4]

Preoperative advance care planning involves alternate decision maker identification by the patient since losing capacity is guaranteed during anesthesia. It is important to encourage patients to share their values with the appointed surrogate, as preparation for the potential need to make decisions on the patient’s behalf. Theoretically, advance care planning preoperatively also includes goals of care conversations for patients that are seriously ill or undergoing high-risk procedures. Goals of care conversations are voluntary discussions for clinicians to explore how much information the patient wants to receive to adapt how to share prognosis. They are followed by exploration of what matters most to the patient, what are the biggest fears and worries about the future of their health, developing a collaborative care plan. [5] Unfortunately, conducting advance care planning conversations is not the norm at the pre-anesthesia clinic, and it is debatable among the medical community who is responsible to do so. Surgeons and anesthesiologists predominantly discuss technical and logistical aspects of the surgery, sparing discussions about values, preferences, long-term postoperative risks, and quality of life. [6] There are multiple barriers for perioperative communication such as lack of time during preoperative visits or on the day of surgery, inadequate training to conduct difficult conversations, fear of “taking away hope” for recovery, among others. [7] It has been also described that surgeons have an implied covenant with the patient once consented for surgery to endure every treatment to avoid death. [8] Interprofessional approach could offer an opportunity to improve perioperative goals of care conversations with involvement of geriatricians or palliative care providers for specific patient populations. Other innovative options to promote advance care planning preoperatively are video-based decision aids that may increase education about treatment options, as well as paper-based decision aids that may increase document completion. [9] It is uncommon for surgeons to discuss prolonged life support with patients undergoing high-risk surgeries. It is particularly important to establish realistic expectations for the postoperative intensive care period as well as to promote sharing goals with surrogates. Video-aids may offer standardized information delivery as a complement to the discussion with their clinicians. [10]

Preoperative Code Status Approach

The approach to code status is one of the items to consider in the plan of care before surgery, including when it is indicated to elicit treatment preferences related to cardiopulmonary resuscitation.

In general, full code by default is assumed for all patients that do not have a Do-Not-Resuscitate (DNR) order. However, default options are only appropriate if they preserve patient's autonomy by allowing individuals to deviate from the norm without barriers, and promoting the best interest of most patients affected. Default options are discouraged when no single decision is clearly optimal for the majority of the patients. Allen and collaborators established a protocol to guide clinicians when it is appropriate to assume a full code by default versus conduct a code status discussion during preoperative evaluation. This proposed protocol takes into consideration the physical status of the individual and the effect that this may have not only on postoperative outcomes, but also on long-term outcomes after cardiopulmonary resuscitation. Based on mortality prediction authors recommend conducting code status discussion preoperatively in patients older than 75 years of age (especially those older than 85), those with functional impairment or frailty, and American Society of Anesthesiologists Physical Status 4 or greater. [11] This approach is in concordance with recently implemented standards in geriatric surgery by the American College of Surgeons. [12] At a minimum, this vulnerable patient group must be informed of the default code status being full attempt at resuscitation and be offered an explanation of the risks and benefits of cardiopulmonary resuscitation. Discussion should take place with the patient, or surrogate decision maker in case the patient is incapacitated by the anesthesiologist, in collaboration with the surgeon if possible. Preferences for other life-sustaining therapies such as mechanical ventilation, feeding tubes, hemodialysis and blood transfusions is guaranteed, when intensive care admission is planned for postoperative care. [12] In an emergency, goals of care and resuscitation preference discussion may not be feasible in which case full code by default remains appropriate. Documentation of an unsuccessful attempt to establish a code status is recommended.

The American Society of Anesthesiologists published guidelines in 1993 pertaining to the practice of automatic suspension of a DNR order in patients undergoing surgery. This practice was deemed to go against patients' autonomy in medical decision making. The ethical guidelines for the anesthesia care of patients with DNR orders by the American Society of Anesthesiologists provides three alternatives: a) full attempt at resuscitation, b) limited attempt at resuscitation with regard to specific resuscitative procedures like chest compressions or defibrillation, and c) limited attempt at resuscitation defined with regard to the patient's goals and values allowing the anesthesiologist to use clinical judgement. It also states the need for documentation and inclusion of other physicians involved in the care. [13] The American College of Surgeons statement requires surgeons to reconsider Advance Directives and DNR orders before surgery, to document and convey the information to the rest of the operating room team, and to find an alternate team member to replace an individual who has an ethical or professional conflict with the decision.[14] The Association of Perioperative Registered Nurses also published guidelines revised in 2020 including the need for goals of care discussion and reconsideration of DNR orders as an integral component of the care of surgical patients. [15]

It is recommended for anesthesiologist to conduct goals of care discussion with the patient or surrogate decision maker if patient is incapacitated detailing the type of anesthesia, what is routinely involved, and the anticipated potential complications. It is of benefit to have the patient's surgeon and primary care provider participate, if able.

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