



Reconsideration of Advance Directives

Practice Guidelines

Considerations for Policy Development

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Practice Guideline

The American Association of Nurse Anesthetists (AANA) recommends, when possible, that the patient, family, proceduralist, and anesthesia team meet during the anesthesia informed consent process to discuss reconsideration of advance directive(s) to develop the plan for care that reflects the patient's wishes.

Purpose

These practice guidelines and considerations for policy development provide a resource for nurse anesthetists, healthcare professionals, healthcare facilities, patients and families to integrate the patient's advance directive wishes with interventions that are core to safe anesthesia care.

Introduction

An advance directive is a legally binding document recognized under state law that allows patients to provide directions to family, friends and healthcare professionals about the healthcare they wish to receive if they become incapacitated or unable to communicate or make decisions regarding their own care.¹⁻⁴ The directive conveys the patient's wishes concerning healthcare interventions (e.g., living will) or delegates authority to another individual to make healthcare decisions on the patient's behalf (e.g., durable or healthcare power of attorney). In order for the advance directive to be valid, the individual must have had decision-making capacity at the time the advance directive was created. Patients have the right to modify their advance directives at any time, but not the right to request interventions that are deemed medically inappropriate or unnecessary.^{1,3,5-7}

For a patient undergoing anesthesia, reconsideration of the advance directive is an important part of the informed consent process. The informed consent process provides the opportunity for the patient and the anesthesia professional to discuss the anesthesia plan of care, including any restrictions outlined in the advance directive.^{8,9} This discussion allows the healthcare team and patient to consider the patient's wishes regarding the procedure and anesthesia. Everyone involved may ask questions and engage in dialogue, so that the patient or legal decision maker can make an informed decision about the anesthesia care plan, including interventions that may be necessary to respond to cardiac or respiratory arrest.

Anesthesia Care for Patients with Advance Directives

Advance directives may include specific provisions that require modification of anesthesia management, such as endotracheal intubation, antibiotic use, blood transfusions, and resuscitative measures (e.g., cardiopulmonary resuscitation (CPR), advanced cardiac life support (ACLS)). Advance directives often restrict use of anesthesia-specific interventions that are intended to be temporary, reversible, and not associated with the natural progression towards a patient’s death.^{6,10} For example, an advance directive may restrict use of an artificial airway and mechanical ventilation support, which may be required during an anesthesia procedure.¹¹ Although, such measures are intended to be temporary, mechanical ventilation in some cases may continue into the postoperative period.

Reconsideration of Advance Directives before Anesthesia

Reconsideration of advance directives before anesthesia provides the patient, family and healthcare team an opportunity to consider the patient’s wishes, goals for care, and the possible interventions during anesthesia or the procedure that are excluded by the advance directive.¹² The process necessitates adequate time, sensitivity, and respectful dialogue in order to share information and clarify any misunderstandings about the goals of care, eliminate non-beneficial or unwanted procedures, and help the patient make an informed decision about the care he or she will receive.^{13,14} The reconsideration process may result in outcomes described below.

Reconsideration of Advance Directive(s)	
Full suspension	All provisions of the advance directive are suspended during anesthesia and the procedure for a specified period of time.
Partial suspension or modification	Specific provisions of the advance directive are suspended or modified during anesthesia and the procedure for a specified period of time.
No suspension	The provisions of the advance directive remain active during anesthesia and the procedure.

Facility Policy and Resource Development Considerations

- Address federal and state specific law and applicable accreditation requirements. Refer to *Appendix A* for an overview of federal and state law, accreditation standards, and other requirements.
- Involve staff from appropriate departments, including the anesthesia department, in the development and plan for policy implementation that describe the management of advance directives during anesthesia and the procedural period.
- Promote reconsideration of advance directives in policy language and replace existing language that supports the automatic suspension of advance directives during anesthesia and procedure.¹⁰
- Promote a “patient-centered” approach in policies.¹⁵
- Develop resources for staff reference in preparation for advance directive reconsideration conversations and informed consent.⁴
- Develop processes to assess and improve staff and team communication skills.¹⁵

Reconsideration of Advance Directives Discussion Guidelines

- Provide sufficient information regarding the patient’s clinical condition, prognosis, and care options for the patient or legal decision maker to make decisions.¹⁶
- Discuss the goals, risks, benefits, implications, and potential outcomes of anesthesia, including perioperative or procedural circumstances that might be reversible.^{4,6,12}

- Describe possible interventions that might be needed during the procedure and provided by anesthesia professionals in the event of cardiac or respiratory impairment or arrest.¹⁶
- Distinguish between anesthesia supportive measures and resuscitative measures.¹⁶
- Identify the interventions that the patient wants and does not want during anesthesia and the procedure and any specific circumstances under which interventions will either be withheld or applied.¹⁶

Example: If sedation or regional anesthesia is planned, discuss the potential consequences of failed sedation or regional anesthesia and the subsequent need for converting to general anesthesia to complete the procedure. Determine the patient's preferences for interventions during general anesthesia and limitations on these interventions.⁴

- Define the duration of time (e.g., intraoperative, postoperative) that the advance directive is to be suspended or modified and if there are situations when the advance directive will be reinstated.^{6,17}

Example: If the patient's condition deteriorates and does not improve within an identified time period, the DNR is reinstated.

Reconsideration of Advance Directives Patient and Family Communication Guidelines

- Use facility resources to prepare for advance directive reconsideration conversations and informed consent.⁴
- Identify legal decision makers early in the patient's care to avoid any potential confusion and miscommunication.¹⁸
- Consider the patient's unique emotional, cultural, religious, and spiritual background and values during all communications.^{3,19}
- Minimize or remove acronyms and clinical jargon.¹⁹
- Balance appreciation of the clinical situation with realistic optimism.¹⁹
- Develop the plan of care reflecting the patient's known wishes when it is not possible to discuss the status of the advance directive with the patient or legal decision maker before the procedure.²⁰
- Involve minors, particularly adolescents or mature children, in discussions during the reconsideration of their advance directive as appropriate to their age and cognitive development, even though their parent or legal guardian will provide informed consent on their behalf.^{4,21,22}
- Parents or guardians who make healthcare decisions on behalf of minors must be available during the procedure for consultation.²³
- Provide scheduled, periodic updates during anesthesia and a point of contact for support to the patient's family or friends.
- Consult with facility resources (e.g., ethics consultant or committee, clergy, social worker) as appropriate.⁶

Resolution of Conscientious Objection Guidelines

When the anesthesia professional is unwilling to provide care due to a conscientious objection related to the patient's advance directive(s):

- Consult the facility's policy or ethics consultant or committee for resources to resolve issues.⁶
- Communicate openly, honestly and respectfully to develop a positive resolution.
- Facilitate the transfer of anesthesia care to an appropriately credentialed anesthesia professional who is able to abide by the patient's wishes.^{4,17,24}

- If another anesthesia professional is unavailable, honor the patient’s decisions and provide care, unless the patient requests care deemed medically inappropriate or unnecessary.²⁵
- Removing oneself from the care of the patient must not harm the patient or constitute a breach of duty.¹⁰

Federal law requires certain facilities participating in Medicare and Medicaid (e.g., hospitals, ambulatory surgical centers) to clearly explain to patients any objections to implementing their advance directives.²⁶⁻²⁸ Refer to *Appendix A* for more information. Such notice must:

- Distinguish between objections that may be raised by the facility and objections that may be raised by the clinician.
- Identify the state law authority for the objection.
- Describe the range of healthcare conditions or procedures affected by the conscience objection.

Reconsideration of Advance Directives Documentation Guidelines

- Date and time of the conversation with the patient or legal representative.
- Summary of the anesthesia plan and who was present during the discussion with the patient.^{10,16,23}
- Interventions to be withheld or modified during anesthesia, including, without limitation, antibiotic use, CPR, and endotracheal intubation and mechanical ventilation.^{16,17}
- Duration of time that advance directive is to be suspended or modified, including how the advance directive applies during the recovery period and circumstances in which the advance directive will be reinstated.²³

Anesthesia and Interdisciplinary Team Communication Guidelines

- Standardize interdisciplinary healthcare team communications with a process that informs and encourages open dialogue to communicate and address issues across care settings (e.g., primary care practitioner, perioperative care areas) of the decisions resulting from reconsideration of the advance directive.^{10,19}
- Discuss the specifics of the reconsideration conversation and changes to the advance directive with the interdisciplinary healthcare team involved in the patient’s procedural care (e.g., surgeon), during hand-off communications and surgical or procedural briefings.^{6,29}
- Discuss plan of care and the duration of the modification to the advance directive with the healthcare team involved in the patient’s procedural care.
- Develop a pre-procedure checklist that includes the elements of the advance directive plan for team engagement and clear communication.

Refer to *Appendix C* and [AANA Considerations for Patient-Centered Perianesthesia Communication](#).³⁰

- Establish agreement within the care team on how to handle issues that may arise during the anesthesia and the surgery or procedure.¹⁹
- Debrief with the procedural team after the case, if possible, to assess the quality of care that was provided and areas that need improvement.
- Engage in initiatives and activities that help the individual provider and healthcare team improve teamwork and communication (e.g., simulation) and improve care quality.

Conclusion

This document offers an evidence-based, patient-centered approach to delivering high-quality healthcare for patients with advance directives. Anesthesia professionals are encouraged to actively engage with the interprofessional team to develop and implement facility advance directives policies and procedures that address the patient's wishes. Reconsideration of advance directives through open communication empowers the patient to contribute to anesthesia planning and make informed decisions about anesthesia care.

Anesthesia professionals are responsible to comply with applicable federal and state laws and regulations, as well as accreditation standards. The following summary briefly discusses general resources and concepts and is not legal advice or a legal opinion. Please check with your facility and healthcare counsel for applicable requirements.

Federal Law

The Patient Self Determination Act (PSDA)³¹, a federal statute that took effect in 1991, requires certain healthcare facilities participating in Medicare and Medicaid to:

- Inform adult individuals in writing of their rights under state law to make decisions concerning their healthcare, including the right to accept or refuse medical treatment and the right to formulate advance directives.
- Ask patients on admission if they have an advance directive.
- Document the advance directive in the medical record upon admission.
- Maintain written policies and procedures regarding advance directives and inform patients in writing about those policies.
- Implement the patient's advance directive to the extent permissible under state law.
- Educate staff and the community about advance directives.
- Not discriminate against patients who do or do not have advance directives.

CMS Requirements

The Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and interpretive guidelines largely mirror the PSDA and require that hospitals, critical access hospitals (CAHs), and ambulatory surgical centers (ASCs), among others, provide written notice of their policies concerning advance directives to patients and have a mechanism in place to allow patients to formulate and update advance directives.^{3,32,33}

If the facility cannot implement an advance directive on the basis of conscience, the notice to patients must clearly explain the objection.²⁶⁻²⁸ Such notice must:

- Distinguish between objections that may be raised by the facility and objections that may be raised by the clinician.
- Identify the state law authority for the objection.
- Describe the range of healthcare conditions or procedures affected by the conscience objection.

Please visit [CMS Conditions for Coverage \(CfCs\) & Conditions of Participations \(CoPs\)](#)¹⁸ to learn more about these requirements.^{34,35}

Accrediting Organizations

National facility accrediting organizations, such as The Joint Commission and DNV GL Healthcare USA address advance directives in their standards in compliance with the CMS requirements and as part of their own accreditation programs. During surveys, these organizations review facility policies and procedures concerning advance directives.^{1,4,7,36} To learn more about an accrediting organization's specific requirements, please visit their respective websites.

State Law and Programs

While state laws vary, all states have laws that address advance directives.³⁷ Generally, regardless of the form that is used to document advance directives, they are honored across state lines.^{38,39} Be aware of specific state law requirements regarding advance directives. State law (statutes, regulations, case law) may include specific provisions or requirements regarding:

- Authority to execute more than one advance directive, which may include conflicting or superseding terms.²¹
- Responsibilities of healthcare providers in honoring advance directives.³⁷
- Rights of healthcare providers to refuse to participate in withholding or withdrawing life sustaining measures.³⁷
- Healthcare provider liability for negligence, battery (i.e., touching another person without his/her consent), violation of constitutional rights, infliction of emotional distress, or other legal claims for failing to comply with advance directives.⁴
- Healthcare provider immunity from civil or criminal liability if they comply in good faith with advance directives.^{37,40}
- Healthcare provider immunity from civil or criminal liability as long as they exercise appropriate clinical judgment and follow the standard of care.^{37,41}
- Identification of who may act as a legal decision maker on the patient's behalf.
- Circumstances under which minors may consent for their own care.^{39,42}

Refer to the [U.S. Living Will Registry](#)[®] for resources on state law requirements and forms required for completing an advance directive.⁴³

Physician Orders for Life Sustaining Treatment (POLST)

Some states have implemented programs that support end-of-life care planning, including the National POLST Paradigm[®]. Programs vary from state to state (e.g., Medical Orders for Life Sustaining Treatment (MOLST) in New York, Tennessee End-of-Life Partnership (TELP)). These programs are intended for patients of advanced age or with serious life-limiting illnesses with a life expectancy of less than one year. POLST is a form that supplements an advance directive; it does not replace it. The POLST form records more specific details of the patient's care decisions and translates those decisions into healthcare orders that follow the patient across care settings. A POLST state program may support patients, families, healthcare providers or communities to:

- Complete supporting documents that compliment an advance directive that provide additional considerations to help healthcare providers address the nuances of specific clinical situations.^{35,44,45}
- Enhance communication between patients and their families and the patient's healthcare providers to promote informed, shared decision making about the patient's end-of-life care.⁴⁴
- Support statewide or community coalitions aimed at improving end-of-life care planning.⁴⁶

Advance Directive: Legally-binding document recognized under state law that allows patients to provide direction to family, friends and healthcare professionals about the healthcare they wish to receive if they becomes incapacitated or unable to communicate or make decisions.⁴⁷ Advance directives may include specific provisions regarding endotracheal intubation, antibiotic use, blood transfusions, use of blood products, and resuscitative measures, including cardiopulmonary resuscitation (CPR).

Allow Natural Death (AND) Order: A healthcare order signed by a healthcare professional that aims to provide comfort care interventions and avoid interventions that would prolong a natural death.^{48,49}

Cardiopulmonary Resuscitation (CPR): An intervention that seeks to restore cardiac and/or respiratory function to individuals who have sustained a cardiac and/or respiratory arrest. This intervention consists of rescue breathing and chest compressions to deliver oxygen to vital organs until heart rhythm can be restored.⁵⁰

Code Status Orders: A healthcare order that designates resuscitative efforts that are to be attempted when a patient suffers cardiopulmonary arrest.

Comfort Care: Interventions that do not cure underlying disease but alleviate pain and discomfort to achieve optimal quality of life available to the patient.

Conscientious Objection: A healthcare provider refuses to perform or participate in the planned or requested procedure based upon his or her own moral, ethical, emotional or other beliefs.

Do-Not-Intubate (DNI) Order: A healthcare order that mandates the withholding of the insertion of an endotracheal (breathing) tube. The order should not be used for patients whose directives allow cardiopulmonary resuscitation.⁵¹ The patient may request the order directly or through an advance directive.⁵²

Do-Not-Attempt Resuscitation (DNAR) Order: A healthcare order that mandates the withholding of attempting resuscitative measures, including CPR, if the patient goes into cardiac or respiratory arrest. Compared to DNR, DNAR does not imply that resuscitation, if attempted, would be successful.^{4,48} The patient may request the order directly or through an advance directive. Generally, these orders are often written by an authorized healthcare provider each time the patient enters the healthcare facility or if there is a change in patient condition.⁵²

Do-Not-Resuscitate (DNR) Order: A healthcare order that mandates the withholding of resuscitative measures, including CPR, if the patient goes into cardiac or respiratory arrest.⁴ The patient may request the order directly or through an advance directive. Generally, these orders are often written by an authorized healthcare provider each time the patient enters the healthcare facility or if there is a change in patient condition.⁵²

Durable, Medical, or Healthcare Power of Attorney: A type of advance directive signed by the patient that appoints a legal decision maker to make decisions on the patient's behalf if the patient is unconscious, lacks decision-making capacity, or is unable to communicate.⁵³

Full Code or Code Blue: Appropriate resuscitative measures are attempted to resuscitate the patient.

Legal Decision Maker: The person named in an advance directive under durable power of medical attorney or allowed under state law to make healthcare decisions for a person who is no longer able to make decisions on his or her own. Other terms that are commonly used include healthcare agent, healthcare proxy, legally authorized representative, or surrogate decision-maker.

Life-Sustaining Intervention: Extraordinary procedures to temporarily replace or support a failing and vital body function (may also be called life supportive measures).

Limited Resuscitation: One of more components (e.g., intubation, chest compressions, defibrillation) of resuscitation are prohibited by the advance directive.

Living Will: Type of advance directive signed by the patient that specifies the course of treatment to be followed by healthcare providers regarding interventions such as life-sustaining treatments, pain management, organ donation.⁵³

No Blood or Blood Products: Healthcare order signed by a healthcare professional to not administer blood and/or blood products to the patient. The patient may request the order directly or through an advance directive. These orders must be written by an authorized healthcare provider each time the patient enters the healthcare facility.⁵²

Order (Healthcare or Medical): Formal directions written in the patient's medical record by a qualified healthcare professional that describes the conduct of the patient's care in stipulated clinical situations. Examples include do-not-resuscitate, do-not-intubate, and no blood product orders. The patient must request the order directly or through an advance directive.⁵²

Palliative Sedation: Use of medications to induce decreased or absent awareness in order to relieve suffering at the end of life.⁵⁴

Persistent Vegetative State: Partial death of the brain from which an individual cannot recover. Chronic state of brain dysfunction in which a person is unaware but may wake, sleep or open their eyes.⁵⁵ Commonly referred to as permanent unconsciousness. Definitions of persistent vegetative state may vary by state.

Physician Orders for Life Sustaining Treatment (POLST) Paradigm: Approach to end-of-life care planning that translates a patient's goals for care at the end of life into medical orders documented in a form that is kept with the patient and follows them across care settings.⁴⁴ A POLST is not an advance directive and does not replace it.⁴⁵

Verbal (Oral) Advance Directives: Patient has verbally conveyed to family members or close acquaintances wishes for the care he or she will receive while incapacitated. State laws vary regarding use of verbal directives.⁵⁶

Appendix C	Sample Advance Directive Reconsideration Checklist
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	Yes	No	NA
Admission			
1. The patient has been informed in writing or verbally of his or her rights under state law to make decisions concerning his or her own healthcare, including the right to accept or refuse medical treatment and the right to formulate advance directives.			
2. The patient has been offered the opportunity to ask questions and obtain additional advance directive information.			
3. Information was provided in a language other than English to the patient or his or her legal decision maker. Document the language and communication method used to provide this information.			
4. The patient has an advance directive in place.			
5. The advance directive is documented in the medical record.			
6. The patient has identified an individual to make decisions on his or her behalf. Document the individual's name, relationship and contact information in the medical record.			
Pre-procedure			
1. The patient or legal decision maker and family participated in a discussion with the proceduralist(s) and anesthesia professional(s) whether to suspend, partially suspend, modify or retain the advance directive during anesthesia with a defined return to advance directive requirements to develop the plan for care as part of the informed consent.			
2. Documentation in the medical record includes:			
a) Individuals present for the advance directive reconsideration discussion.			
b) Plan for anesthesia and procedural care.			
c) Status of the advance directive (e.g., suspended, modified) during anesthesia and the procedure.			
d) Duration of time that the advance directive is suspended or modified, including how the advance directive applies during the recovery period.			
e) Circumstances in which the advance directive will be reinstated in full.			

NA: not applicable

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