Ethics, Clinical Reality and the Law - are they compatable?

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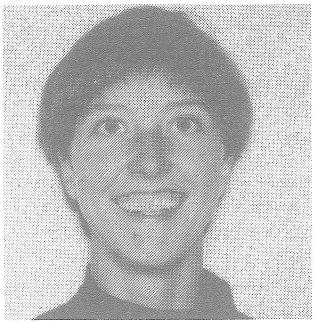
"Do Not Resuscitate" (DNR) orders illustrate some of the complexities involved in applying ethics and the law to a clinical situation.

DNR orders have become necessary over the last decades. Cardio Pulmonary Resuscitation (CPR) allows us to attempt to prolong life in a manner that is not always sucessful and rarely dignified. CPR applied globally to deaths within the hospital has discharge success rates of 10 to 20% (1,7). There are certain illnesses / conditions that predict almost certain non success (1,11,12,13,14,15).

The aspects of New Zealand law relevant to DNR orders are:
1) Doctors are not obliged to offer a treatment that will be non-benefical to the patient. Therefore if CPR is not clinically indicated a DNR order can be given, consent from the patient is not required.
2) The patient is the prime decision maker regarding medical treatment or nontreatment options provided they are mentally competent and over 16 (exception; if the patient is married and under 16 they are the prime decision maker). They can refuse treatment even if it is deemed medically beneficial. They cannot, however, demand treatment that is deemed medically nonbeneficial. Thus with respect to DNR orders they may choose not to be resuscitated in situations where it is likely to be beneficial or where it is not clear if it will be beneficial or not. They cannot however demand resuscitation where it is medically nonbeneficial.

3) Where a patient who was previously mentally competent becomes mentally incompetent and is over 20 decisions about their medical treatment rest with the senior medical person caring for them.

4) For patients under 16, or under 20 to whom special provisions apply, consent must be obtained from other sources (parents, guardian, district judge, director of social welfare, iwi authority, welfare guardian, high court).



Defining what is also relevant ethically is not as clear. Principles and rules of appropriate conduct do change not only over time but between different groups and different situations. Most would agree that we should respect the patient, allow them to express their opinion without coercion and be honest with them. Many would go further and argue that patient autonomy is imperative and that despite the law the ultimate decision must rest with the patient even when CPR is of no medical benefit. However others may argue that we have an ethical obligation to prevent unnecessary indignities to the patient and that if CPR is nonbeneficial it should not be applied.

How are DNR orders used in clinical practice?

> It is legal for DNR orders to be issued without consent or discussion if CPR is deemed medically inappropriate. Is that ethically acceptable?

The Dunedin hospital policy is for CPR to be performed on all patients found pulseless and / or not breathing unless there is documentation to the contrary.

DNR orders are used frequently: 86% of deaths on the 4th and 8th floors during a four month period in 1994 had DNR orders in place at the time of death (2).

Medical and nursing staff replying to a questionaire at Dunedin hospital were unaware of some details of NZ law (2). Only 18% were aware that when a patient over 20 has become incompetent to make a decision that the consultant is responsible for decisions regarding their medical management. Only 46% were aware that a DNR order could be given without a patient's consent if CPR was medically nonbeneficial. *If the law is not known it cannot be applied.*

It is legal for DNR orders to be issued without consent or discussion if CPR is deemed medically inappropriate. Is that ethically acceptable? The answer is not clear. If one believes that patient autonomy is paramount then the answer is no. If one believes we have a duty to prevent unnecessary indignities to patients then it may be acceptable for them to be unaware of the DNR order. It could also be argued that it is acceptable because we only offer and discuss other medical treatments with patients when there is potential benefit. We do not discuss radiotherapy as an option for someone presenting with acute appedicitis because it is of no benefit. Therefore if CPR is of no medical benefit we need not discuss it. However many of us abhor the idea that someone may label us not for resuscitation without our knowledge. Additionally sometimes the nonbenefit of CPR is not as clear cut as other medical treatments. Furthermore CPR has become something that is potentially applicable to all deaths. In order to have a DNR order an active step needs to be taken to label the patient not for resuscitation - we do not do this with any other treatment. Therefore I believe that the patient should be informed of the decision and the reason why. This shows respect for the patient, allows them to express their opinion and is honest.

During a four month period at Dunedin hospital in 1994 30% of the time when DNR orders were issued either no discussion occured with the patient and or family or no discussion was documented (2). In a few instances relatives but not the patient were involved in the discussion even though the patient was mentally competent. This is consistent with work by other researchers (3,4).

Some staff commented that it is not always appropriate to involve patients in these discussions or decisions (2). We may wish to ignore this and say that these staff are unduly paternalistic. However this glosses over a difficult issue that may be important. It is not only staff but also patients who believe that it is not always appropriate to discuss the issue with a patient. Liddle et al (in a UK study) (5) found that only 28% of patients would have wanted to be involved in decisions or discussions about their resuscitation status at admission and that 43% believed that the doctor alone should take responsibility.

The situation is further complicated by staff discomfort. 51% of staff returning a questionnaire listed the difficulty of raising and discussing these issues with patients as a barrier to obtaining DNR orders (2).

Thus the question: "is it ethical not to inform patients of their DNR status?" is quite complex. It is difficult to say that patients should always be informed of their resuscitation status when both clinicians and patients say it is not always appropriate for patients to be involved in the discussion of resuscitation issues. There may be situations where raising such a topic with the patient may have deleterious effects. It is important nonetheless, that clinicians distinguish their discomfort from that of the patients. There is no clear way of knowing in advance which patients would have preferred that the topic had never been raised for discussion. The best we can achieve is to offer to discuss end of life concerns and resuscitation issues with patients where DNR orders are medically indicated. Patients may turn us down but we should rarely make this decision for them.

What of the situation where a patient is dying, is unable to accept this and wants resuscitation, despite resuscitation conferring no benefit. Legally the DNR order may be given but do we break this patient's trust and faith in the team caring for him/her? Should we covertly place a DNR order or should we ignore our legal ability to do this and respect the patients wish even if resuscitation is futile? Again it is not an easy issue. It is difficult for medical and nursing staff to carry out resuscitation procedures where they are futile. Many times this situation can probably be resolved by further discussion and time spent with the patient.

What about the patients over 20 incompetent to make a decision?

11% of admissions to general medical and surgical floors in Dunedin hospital are unable to advocate for themselves because of confusion, dementia or disorders of speech (6). Responsibility for decisions about their medical management lies with the consultant. Most staff are unaware of the consultant's responsibility for medical management decisions in this situation (2). Most thought it was the next of kin. It is likely that the public are unaware of the legal situation as well. This may mean that relatives are being asked to take responsibilty for these decisions. Relatives have both financial and emotional stakes in the patient. Burden, guilt and conflict within families if they were asked to make DNR decisions was a concern raised by 6% of patients surveyed as part of a patient survey on DNR orders (6). This may be a real issue for some families if they are put in the position of making sometimes difficult decisions. The opposite situation is possible too - where the law is followed and this decision is taken out of the family's hands they may feel powerless and overruled. The law guides us in this situation and says that the decision about medical treatments lies with the senior medical person who is responsible for the patients care. Staff need to become more aware of the legal issues. Where CPR is clearly of no medical benefit informing the family of this is probably adequate. Where CPR may be medically beneficial in a physiological sense but where a value judgement is made that the quality of life is not worth resuscitating the person then we should establish that this is what the person would have wanted. Doctors don't always make the same decisions as patients would themselves (5). This may require more detailed discussion with the family. They too may not make the same decision that the patient would have (9,10) but they at least have the advantage of knowing the patient when they were of sound mind.

Are clinicians obliged to always follow DNR orders made by patients? What if they are unreasonable? What of fear of litigation?

Are clinicians obliged to always follow DNR orders made by patients? What if they are unreasonable? What of fear of litigation? This later situation may be especially pertinent to the operating room or to an arrest occuring as a result of some error or action of a staff member. In the operating room both surgical and anaesthetic interventions may result in unstable physiology that at times may lead to arrest. It is quite plausible for patients with DNR orders to present for surgery either for palliative or treatment procedures. If we are mandated to correct the instability but not the arrest we are put in a difficult position. If the patient arrests and we don't intervene we could be held responsible for an untimely death (not all patients with DNR orders are likely to die in the immediate future (2)). If we do intervene we are overriding the patients legal right to refuse treatment. I think that there are situations when clinicians may be justified in overuling a patients prior decision. This may be one of them. Do we act unethically/illegally in doing so? Perhaps this can only be judged later when the outcome is one the patient wouldn't have wanted. It may be possible to discuss these difficulties with the patient preoperatively and ask them to suspend the DNR order for the duration of surgery.

Are we obliged to follow DNR orders that patients request when we consider them to be unreasonable? I think our obligation in this circumstance is to establish that this is a fully informed decision on behalf of the patient. We may try to persuade them otherwise but if they are of sound mind and are making an informed decision we should respect it. Patients may make what we consider unreasonable decisions for reasonable and logical reasons. For example a 52 year old woman presenting with an acute myocardial infarct says she does not want CPR in the event of an arrest. Unreasonable? Her chances of sucessful resuscitation are good. She illustrates that she understands the issues involved but that she does not want resuscitation because her husband arrested at home and was

"sucessfully" resuscitated to a persistent vegatative state which he remained in for 6 months until he died. She does not want the possibility of this no matter how remote. Reasonable.

Finally if we are to allow patients to make fully informed decisions in situations where it is not clear that CPR will be beneficial or not then we need to provide them with adequate information. Murphy et al (7) found that when patients were in possession of the facts that they chose resuscitation far less frequently than previously.

We found that adult inpatients had a poorer understanding of a passage about resuscitation than 12 year old schoolchildren (8). This challenges clinicians to not only give explanations but take steps to make sure that they have been understood. This however takes time. Time is a limited resource in our hospitals in the 1990's. Patient to staff ratios are increasing and success of a service is measured by greatest throughput at least cost. Indeed 38% of staff identified time limitations as a barrier in obtaining DNR order (2).

Are ethics, clinical reality and the law compatible? The answer is not clearly yes or no. The ethical issues of importance may vary from case to case. It may not always be possible to follow the ideal without causing distress to some patients. The right action in one case may be the wrong in another. Ethical guidelines need to be drawn in a loose framework. The current hospital policy has guidelines which are well drawn up - they suggest but do not mandate what the appropriate behaviour is in a particular situation.

There are clear legal guidelines but at times we may need to go outside of these to act in ways that take into account the needs of a particular patient or situation. The clinical reality is that staff work within time constraints that don't always allow the time for adequate discussions and that staff are unaware of some aspects of NZ law. Additionally clinical staff are also human beings that interact in human ways. Part of this aids interaction with patients but we also need to recognise the discomfort that sometimes occurs when raising these issues (that may impede interaction) with patients.

DNR orders are part of modern medicine. They allow death with dignity. They are used frequently.

We found that adult inpatients had a poorer understanding of a passage about resuscitation than 12 year old schoolchildren

Legal guidelines are clear but not always practical or sensitive. Ethical guidelines can be drawn up but only loosely. The constraints and practical realities of clinical practice need to be recognised in drawing up policy documents.

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Summer School

Planning is underway for the Centre's 1996 Summer School. The school will be organised into three sections: "Research ethics" (designed for those involved or interested in ethics committees), "ethics education" and "the moral management of HealthCare". The first stream will take place over the weekend of 9-11 February and the other streams will run con-currently, 12-14 February.

There will be overseas contributors, but we are planning a programme which will value New Zealand knowledge and experience.

The Summer School will again be held at Knox College in Dunedin, the site of earlier successful Schools.

If you would like to be placed on a mailing list for further information, please write to:

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