



Consent/End of Life

Do-not-resuscitate order: a view throughout the world

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Abstract Resuscitation has the ability to reverse premature death. It can also prolong terminal illness, increase discomfort, and consume resources. The do-not-resuscitate (DNR) order and advance directives are still a debated issue in critical care. This review will focus on several aspects, regarding withholding and/or withdrawing therapies and advance directives in different continents. It is widely known that there is a great diversity of cultural and religious beliefs in society, and therefore, some critical ethical and legal issues have still to be solved. To achieve a consensus, we believe in the priority of continuing education and training programs for health care professionals. It is our opinion that a serious reflection on ethical values and principles would be useful to understand the definition of medical professionalism to make it possible to undertake the best way to avoid futile and aggressive care. There is evidence of the lack of DNR order policy worldwide. Therefore, it appears clear that there is a need for standardization. To improve the attitude about the DNR order, it is necessary to achieve several goals such as: increased communication, consensus on law, increased trust among patients and health care systems, and improved standards and quality of care to respect the patient's will and the family's role. © 2013 Elsevier Inc. All rights reserved.

1. Introduction

The advance directives (ADs) are "oral or written statement in which people declare their treatment prefer-

ences in the event that they lose decision-making capacity," they include withholding or withdrawing interventions [1]. One of the most discussed ADs is the do-not-resuscitate (DNR) order, a written medical directive that documents a patient's decision regarding his/her desire to avoid cardiopulmonary resuscitation (CPR). The DNR order is one of the most important patient care directives that can be issued, seeing that it has dramatic and irreversible consequences [2]. Resuscitation has the ability to reverse premature death, but it can also prolong terminal illness, increase the family's anxiety, and have serious economical consequences [3]. Despite the desire to respect the patient's autonomy, there are many reasons why withholding resuscitation maneuvers may complicate the management

Abbreviations: DNR, do-not-resuscitate order; Ads, advance directives; EU, European Union; CPR, cardiopulmonary resuscitation; ED, emergency department; ICU, intensive care unit; DPAHC, durable power of attorney for health care; PSDA, Patient Self-Determination Act.

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of critical illness and perioperative care. Concerns regarding these care directives have been raised by health care workers, patients, and their families. Hence, this explains the need to seriously consider the issues surrounding DNR orders and ADs. The definition of DNR order does not change among countries; it is the attitude to deal with it that changes. The objectives of this review will be to describe the different attitudes in various countries regarding these arguments and to present our contribution that focuses on a correct introduction of these issues to future health care provider generations.

2. Epidemiology

Disparities regarding DNR order have been ascertained worldwide and also in the United States. Do-not-resuscitate orders are, often, stated to the seriously ill but seem to be underused—even among the sickest. More often than not, the diagnosis at admission and the functional impairment are less considered than the age of the patient. Do-not-resuscitate orders are frequently stated to older patients, women, and patients with dementia [4,5]. Furthermore, care directives are stated less often to Afro-Americans, patients with Medicaid insurance, and those admitted to rural hospitals [4,5]. Do-not-resuscitate orders are significantly higher in private nonprofit hospitals and also in smaller ones. On the contrary, they are lower in academic hospitals. Standardized rates of the use of DNR orders vary across the states, and the highest rates are among patients from rural areas [4,5]. However, few studies have investigated the role of hospital factors and, in particular, geographic variations with respects to the use of DNR orders [6].

3. Medical futility, informed consent, and informed assent

The AD- and DNR order-obtaining process is strictly linked to 2 main concepts: the “medical futility” and the “patient/family’s consent.”

A direct link is present between ADs and medical futility. Often, a DNR order and other ADs are triggered by the recognition of the “futility” of the medical treatments. It is defined “futile” a treatment that is nonbeneficial, ineffective, and/or inappropriate [7] or, as per new definitions, an intervention that is unlikely to restore, maintain, or enhance a life that the patient can be aware of [8]. The definition and value of the futility principle in medical decision making has been extensively discussed, and futility is currently being used in clinical practices across the United States and around the world [7–9].

Another key point for obtaining ADs and, especially, a signed DNR order is the expression of “consent.” The “informed consent” is defined as “permission obtained from

a patient to perform a specific test or procedure. Informed consent is required before most invasive procedures are performed and before a patient is admitted to a research study. The document used must be written in a language understood by the patient and be dated and signed by the patient and at least one witness. Signed consent should be obtained by the person performing the procedure” [10]. There is evidence that the process of obtaining informed consent may cause considerable distress for patients and families [11–13]. A valid alternative, as suggested by Curtis and Burt [11], may consider an “informed assent” defined as a document by which the patient or family is explicitly invited to defer to the clinicians’ judgment in favor of withholding or withdrawing life-sustaining therapy. It is understood that this alternative should not be offered when clinicians are uncertain about the possibility of success or when the clinicians’ convictions about withholding or withdrawing treatment are based on their value judgments regarding the patient’s outcome and quality of life.

The ethical property of the assenting process depends on the clinicians’ careful attention to the particular wishes and needs of specific patients and their families. It is equally true that the process of informed consent demands from physicians that they have good communicative skills and that they spend more quality time with patients and their families [11]. An alternative to this is a written “comfort measures only” order, defined as the administration of drugs such as narcotics and sedatives to prevent and treat symptomatic discomfort occurring during the dying process. Nursing care, including suctioning of secretions, positioning, and so on, was continued. Spiritual and emotional support was provided as requested by patients or families [14]. Nevertheless, even if expressed, it is insufficient for redirecting changes in the care of a dying patient. A DNR order is part of advanced directives, and many other medical interventions may be withheld upon discussion with the patient or the patient’s surrogate. The rationale of a DNR order is not to limit aspects of care but to avoid overtreatment, and it should not be assumed as a limit for escalation of treatment.

4. Ethics and advanced directives

Around the world, there is still confusion about the meaning of advanced directives and how they have to be followed—the United States, European, and Australian health care systems are still working out the details [15]. For a better understanding of the role of various forms of advanced directives, especially DNR order, it is important to consider that the motivating moral idea behind ADs is similar to that of informed consent. Advance directives are, in essence, a proactive informed refusal of therapies in a future state of incapacity. Informed consent is typically used in the process of obtaining permission to perform interventions (eg,

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