In times past, people died from minor illnesses because science had not yet developed medical cures. Today, an impressive range of medical therapies and life-support technologies offer not only help to fight disease but, at times, a considerable extension of good quality of life. A key ethical challenge that these medical and technological advances present is to determine whether there is always an obligation to prolong human life simply because it is possible to do so.

The following case presents a rather ordinary situation of advanced and complex illness in an elderly man. His wishes have not been expressed either through conversations linked to Advance Care Planning or in a more specific Advance Directive and his family voice their serious concerns about the clinician’s suggestion that they agree to a Do Not Attempt Resuscitation (DNAR) order for their father. As you read the case, jot down your immediate unanalyzed response to the situation described.

### When God Might Intervene

David Sanchez is 82 years old and has many serious medical problems, including ischemic heart disease, hypertension and diabetes mellitus. He has had a series of debilitating strokes that have left him severely disabled and unable to communicate his wishes. His health care providers feel that he would not benefit from resuscitation attempts if he were to suffer a cardiac arrest and suggest to his family that a DNAR order be placed on his chart.

While very aware of the grief experienced by the family the doctor explains to the family that prolonging life with cardiopulmonary resuscitation would not benefit their father and the distress of the process itself is sometimes more cruel than compassionate.

The devout Christian family is quite upset and reject this suggestion. They can’t see that continuing to live is any burden on them or their father. They believe that God could still heal their father and they accuse the healthcare team of trying to ‘play God’. They ask to see the hospital Chaplain.

### Discussion

Normally, unless a specific order to the contrary (e.g. DNAR) has been recorded on the person’s health record by the responsible doctor or a valid patient Advance Directive exists, cardiopulmonary resuscitation (CPR) is used as a standard intervention in virtually all cases of sudden cardiac or respiratory arrest.

**What is a DNAR Order?**

A DNAR order may generally be described as a note primarily written and signed by a doctor but which could involve the patient, healthcare team and family, stating that in certain circumstances should the patient suffer from cardiopulmonary failure, CPR should not be attempted. Such an order is only relevant to not attempting CPR and does not apply to the withholding of any other treatment. At present the ethical and legal status of DNAR orders in Ireland is uncertain; there are no clear professional or legal guidelines to assist health professionals to make decisions in relation to CPR and practices seem to vary across different hospital settings in the country.
Balancing Benefits and Burdens

In the case of David, health professionals have judged CPR inappropriate and are relying on the benefit-burden judgement known as the principle of proportionality. The principle of proportionality is widely cited as a moral rule of thumb for decision-making about withholding or withdrawing Life Prolonging Treatments (LPTs) such as CPR. It states that whether or not a particular LPT for a patient is morally required should be evaluated in terms of its potential risks or burdens and probable benefits. If the risks or burdens to the patient outweigh the benefits, then the treatment is clinically inappropriate and not morally required.

A fundamental ethical question in applying the principle concerns the issue of who takes part in any decision that determines the relative burdens and benefits of a LPT? If a patient has capacity and wishes to participate in decision-making, then their input is important in any judgement about benefits and burdens of treatments proposed. If a patient currently lacks capacity their past wishes, if known, should be taken into account. Moreover, the right of self-determination of a competent patient to refuse a medical treatment is a fundamental ethical value in Ireland, even if a clinician judges the treatment necessary to save the patient’s life. In the case, When God Might Intervene, the patient’s own wishes seem to be unknown and the family disagree with the judgement of the healthcare team. They cannot see what is so burdensome about continued life for their father. They might believe that prolonging their father’s life benefits him because:

- Recovery of awareness by David is remotely possible, perhaps by a miracle;
- Their father is better off alive than dead.

Here, it is essential that the healthcare team engage in conversation with David’s family. This is not only out of respect for the family who are wondering about David’s condition but the conversation also needs to ensure that the family understands the CPR procedure as realistically as possible. This understanding is seldom the case with families. In their research with practitioners in Irish hospitals, Quinlan and O’Neill found that patients and families often lacked knowledge and understanding about active treatments mentioned to them such as ‘PEG feeding’, ‘subcut fluids’, ‘defibbing’ and ‘shocking hearts back to life’ (Quinlan, C., & O’Neill, C. [2009] Practitioners’ perspectives on patient autonomy at end of life. Dublin: Irish Hospice Foundation, p.36). It is easy to see how patients or families end up confused and are intimidated about asking ‘what does this mean?’ when hearing abbreviated jargon from doctors or nurses.

In light of your reading and understanding of When God Might Intervene; discuss your response to the following suggestions in relation to professional responsibilities and consider any others that you think should be added.
Suggested Professional Responsibilities

1. **Determine patient competence:**
   Initially it is most important to determine the competence or incompetence of patients who are deciding on DNAR or CPR. When an incompetent person’s wishes are not known, treatment decisions must be based on the person’s overall best interests (based on a judgement about the clinical outcomes and known preferences and values of the patient [see Study Session 4]).

2. **Engage with patients where possible:**
   Although the legal framework for advance decision making is still limited in Ireland, professionals should engage with patients where possible in order to ascertain the treatment they would wish to receive if they lose capacity. Where a patient has given an indication of their own values or preferences either in a document or conversation both the professionals and the family are more informed and supported in deciding what to do.

3. **Provide information:**
   The nature, benefits and risks of CPR as they apply to the patient’s situation should be explained to the family. The family should be reassured that a DNAR decision applies solely to CPR. All other treatment and care which are appropriate, including palliative care are not precluded and will not be influenced by a DNAR decision.

4. **Avoid futile and harmful treatment:**
   Patient autonomy and the decision-making role of families are limited. A patient’s, or family’s, request for a LPT does not have to be granted if health professionals judge the request to be without benefit for this patient in this particular condition. In brief, the clinician does not have to grant what he or she judges to be ‘futile’ or ‘harmful’ treatment. However, it is important that informative conversation with any competent patient be offered to ensure understanding of why a clinician refusal is given. Such communication is also an important opportunity to give hope to the patient and/or the family that a medical refusal of the patient’s request for a LPT or other therapy does not mean that they will be abandoned by health professionals or left without optimal palliative care.

5. **Document decisions:** Any decision that CPR will not be attempted for an incapacitated patient should be documented on the patient’s records and details given of components that went into the ‘best interests’ judgement.

6. ??

Key Terms

**Life Prolonging Treatment (LPT)**
LPT is any medical intervention, technology, procedure or medication that is administered to provide benefit for a patient and to forestall the moment of death. These treatments may include, but are not limited to, mechanical ventilation, artificial nutrition and hydration, cardiopulmonary resuscitation, haemodialysis, chemotherapy, or certain medications including antibiotics. At the time a LPT is introduced it may be important for the health professional to help the patient to anticipate what withdrawal of the treatment might mean and when and how such decisions could be made.

**The Principle of Proportionality**
The principle of proportionality requires that the decision process about medical treatments should follow the general rule to maximise benefit and avoid undue burden.
An Advance Directive

An Advance Directive or decision (sometimes known as a ‘living will’) is a decision made by a person while he or she has decision-making capacity regarding the medical treatment he or she would wish to receive (and more frequently not to receive) if he or she subsequently loses capacity. It allows patients to direct their care even beyond incapacity. An Advance Directive may be stated in very general terms: i.e., ‘I would not wish to receive treatment for cancer’ or in much more specific terms: i.e., outlining specific treatments that a person would not wish to receive, for example, a patient may request a DNAR order to be placed on his or her notes stating that he or she would not wish to be artificially resuscitated in certain circumstances. Advance Directives are usually made in writing and this is advisable because it provides a clearly indication of the person’s wishes.

Activities

1. Reflect back on the particulars of When God Might Intervene. David’s life is in the balance: Would CPR provide benefit? What kind of benefit do you think CPR might provide? Can you understand how David thinks that his continued existence can be construed as a benefit even if there is no realistic opportunity for David to continue having a biographical or personal life?

2. What means would you suggest for resolving the disagreements between the family, doctors and nurses? When faced with continued resistance to clinical advice, is it ever legally or morally justified to simply go ahead and write up a DNAR without family consent?

3. Research in Ireland indicates that conversations with patients and families to provide helpful information and aid understanding of CPR/DNAR are uncommon occurrences. Documentation of such decisions with the circumstances and reasoning for the decision noted is also uncommon. Certainly, patient records do not show evidence of such conversations aimed at discovering patient wishes. Is this the case in the hospital where you are working? How does the presence/or lack of a clear policy in relation to CPR/DNAR affect your practice?

4. In the absence of policy guidelines or legislation it is not surprising that health professionals may decide to ‘walk slowly’ if a patient arrests and CPR is thought to be a futile therapy for that individual. Have you ever ‘walked slowly’ in these circumstances?

5. Two recent Irish reports have called for the introduction of Advance Directives in legislation:
   and the recent Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 7th ed. from the Medical Council of Ireland (2009) refer to the need to involve competent patients in some form of Advance Planning for end-of-life treatment and care:
   - http://www.medicalcouncil.ie/Professional-Standards/Professional-Conduct-Ethics/ Accessed 31 August 2010
   Download one of these documents and briefly summarize what it has to say about Advance Directives. Share your findings with your colleagues.
**Key Readings**

British Medical Association (BMA), Resuscitation Council UK, & Royal College of Nursing (RCN). (2007). Decisions relating to cardiopulmonary resuscitation: a joint statement from the BMA, the Resuscitation Council (UK) and the Royal College of Nursing. London: Resuscitation Council (UK), British Medical Association and the Royal College of Nursing.


Study Session 6

The Ethics of Life Prolonging Treatments (LPTs)