DNAR Guidelines from ICMR-meeting a felt need

Response to: DNAR Guidelines: supporting EOL decisions. Olinda Timms

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We note with interest Dr Olinda Timms’ comments [1] on the ICMR guidelines for Do-not-Attempt-Resuscitation (DNAR) published recently [2] thanking her for raising some pertinent issues.

One of the reservations expressed in this commentary is the lack of details regarding the legality of DNAR decisions in the ICMR document. There is, to date, no clear pronouncement on DNAR in Indian Law. That should be no reason not to formulate an ethical and professional consensus to clarify when Cardio Pulmonary Resuscitation (CPR), a medical procedure, [3] may not be indicated. Evidence-based practice, grounded in ethics and pragmatism has always preceded law and legislation. Otherwise it would be a case of the cart before the horse. However, in order to address legal concerns, and to ensure consistency with existing laws, the document was legally validated by 3 lawyers who were part of the Core Committee and the Expert Group.

DNAR has been an integral part of medical practice worldwide for more than 45 years. [4] In the US, the first of such orders was written in 1974 followed by a codified Law only in 1988. The Law served to considerably reduce unnecessary CPR as well as unilateral DNAR. [5] It is important to mention that outcomes of CPR in critically ill patients are beneficial in less than 5%. [6] The consequences, to the individual families and to the society at large, are highly adverse, for CPR may result in survival but with poor neurological outcome. In India, despite much avoidable suffering to patients and families and moral distress to caregivers, there is no formal acceptance of the grim realities due to which DNAR is considered essential in modern Medicine.

CPR, under the circumstances of terminal disease, is therefore usually not acceptable.[7]It is pertinent to point out that most of the litigations around CPR in the world have been for the breach of patient’s rights in performing CPR, disregarding Advance Directives.[8] The tenets of respect for Autonomy and of weighing benefit vs. harm to fulfill the obligations of Beneficence and Non Malfeasance, are ignored, when CPR is done regardless of the phase of the illness or the patient’s choice. The ICMR document aims at defining the ethical standards of care with respect to CPR/DNAR. In any case, legal liability, as with any medical decision, is determined by care standards set by professional consensus. The Constitutional validity of treatment refusal and withholding of life-prolonging treatment was well established for India in the *Common Cause* judgment.[9]

As noted by Dr Timms, indeed it would be desirable for a professional regulatory authority such as the National Medical Commission to formulate policies on matters such as DNAR or the overarching End of Life Care. In the absence of such guidance, the ICMR initiative has answered the long-felt needs of medical caregivers confronted daily, with ethical dilemmas in managing terminally ill patients. It is appropriate that ICMR, the regulatory authority for research ethics, formulates guidelines for DNAR, which has as much to do with ethics as with clinical decision-making.

Due care and diligence went into the formation of the Expert Group to ensure it is truly representative. The core Committee included, apart from the ICMR Bioethics department, several practicing clinicians with subject expertise-an intensivist , an anaesthesiologist-cum-palliative care specialist, a neurologist with interest in neuro-palliative care and physicians. The group was drawn from both Public and Private sectors. In recognition of the multi-professional intersections in the field, the core committee and advisory team included legal experts, ethicists and palliative care specialists among others. The consultation process involved a)four sessions among core group members with multidisciplinary and multi professional invitees; b)setting up of an open round of public consultation on the ICMR Bioethics Unit webpage for 4 weeks for comments by patients and the lay public; and finally c) a national consultation with a multi professional representation and lay participation. Participation was kept open through online registration on the ICMR website with 20 slots reserved for patients or any interested citizens. The consultation was widely publicized resulting in 60 participants in all. The final document was drafted based on all of the above mentioned rounds. We therefore, have reasons to believe that the document embodies the perspectives of a broad spectrum of stakeholders.

Traditionally, the term “treating physician” denotes the one under whom a patient is admitted. In a unit, it would imply the unit head or an assigned physician. In current times, it is usual for a patient to be looked after by a team. Therefore, even if the patient is attended by a junior physician as a first responder, the overall responsibility and accountability lies with the treating physician. The term “physician in-charge” likewise specifically denotes the Head of the unit. The document thus clearly recommends that the most senior member of the team should take charge of the communication leading up to the decision. In case of transfer of care of the patient to another department, the onus of the DNAR decision, as with overall care, would be transferred to the receiving department.

It is valid and necessary, as pointed out by Dr Timms that a DNAR decision should be disseminated to the entire care-giving team to avoid inadvertent CPR. Indeed, this is the spirit of a formal process and documentation of a DNAR decision. Errors are prone to occur in a crisis, when CPR is unanticipated and neither the family nor the treating team is prepared. Identification ‘tags’ have been a practice but the treating team runs the risk of being suspected of negative stereotyping and discrimination.[10]The ICMR document has clarified unambiguously, that DNAR does not include decisions to withdraw or withhold other life-prolonging treatments. It is possible to continue with curative treatments while precluding CPR. It is crucial for hospitals to create a culture of ethical decision-making involving the entire team, including the nurses. We believe DNAR decision (“no code”) should be part of the doctor and nursing notes and should be communicated in the hand over as with other clinical details. This should be complemented by promoting end of life care literacy and training.

Privacy and confidentiality in discussing prognosis and further course of management should be a given. It is clear from the document that no patient or family can demand a procedure, including CPR that is evidently not medically indicated. However, ethical principles behoove the care-giving team to discuss openly and completely as outlined in the flow chart of the ICMR document. Disagreements are to be resolved through multiple sessions and seeking second opinions. Another mechanism for dispute redressal could be referral to an ethics committee. Indian Critical Care and Palliative Care Societies have always recommended setting up of such a committee for the oversight of treatment limiting decisions. [11]Such a provision is also recommended recently in the EOLC policies of the Kasturba Medical College & Manipal group of hospitals[12 ] and the All India Institute of Medical Sciences.[13] In practice, these decisions are made after building a relationship of trust. Therefore, referring to another body of physicians would render the process cumbersome and hamper the primary objective of mitigating patient/family suffering and physician moral distress. Standard guidelines in other countries with long experience of DNAR recommend that caregivers and patient/family work together as a rule and refer to an independent committee only for conflict resolution.[7,14]

The word “vegetative” is used for its technical specificity as this guidance is for the professional community. The FAQ in the supplement is meant especially for the lay public. While discussing the clinical state with the family, we suggest the use of euphemistic expressions such as “irreversible coma” while retaining accuracy of the description.

The value of a guideline is ultimately tested by its applicability in the real world. Departure from a habitual but flawed “ritualistic CPR” is expected to take time. At the same time, many physicians will feel empowered to write DNAR orders with more clarity and conviction than hitherto. The process, as recommended by the document would also ensure that the decisions are reflective, empathic and transparent.

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