NATIONAL BIOETHICS COMMISSION

R E C O M M E N D A T I O N

BINDING OF "DO-NOT-RESUSCITATE ORDERS" (DNRs)

The Hellenic National Bioethics Commission, within its jurisdiction, reviewed the issue of “Do-Not-Resuscitate Orders” (DNRs), upon a relevant request submitted by the Ethics Committee of the “Hygeia” Hospital. DNRs are a form of “refusal of treatment”, which the patient can express beforehand in case he/she suffers cardio-pulmonary arrest while receiving treatment. The question arising, in this matter, is whether this refusal (once considered authentic, of course) can be deemed binding for the attending physician as well the patient’s relatives.

The Commission holds this issue as particularly important, given that it concerns the limits of patient autonomy on the one hand, as well as the scope of the physician’s duty, on the other hand. It also recalls that it has previously considered this issue in a previous Opinion on the broader issue of “artificial prolongation of life” (2006).

In light of the above, the Commission held hearings with T. Ksanthos, President of the Greek Society of Cardiopulmonary Resuscitation on 20 March 2013, G. Zacharopoulos, President of the Scientific Committee of “Hygeia Hospital” on 8 April 2013 and A. Karampinis, Director of ICU, Onassis Cardiac Surgery Center on 3 July 2013. The issue was further discussed in pre-arranged meetings between the Commission’s scientific officers and patient associations.

1. The data

"Do-not-Resuscitate Orders" constitute expressions of the so-called “advance directives” and more specifically the so-called “living wills”. Advance directives can be defined as one’s wishes regarding his/her indicated medical treatment, in case the person concerned becomes incapable of making autonomous relevant choices. This can be the result of either an accident or a serious disease, once he/she has suffered damage to his/her basic mental functions (e.g. loss of consciousness, slipping into coma, etc.).

These directives are usually of two kinds: i. they either designate a proxy for the person concerned, who is authorized to make decisions regarding the conduct or not of medical acts at the critical time, or ii. they designate specific medical acts which the person concerned refuses or wishes, thus being referred to as “living wills”.

In the first case, the proxy’s will is exclusive; it prevails, that is, according to the wish of the person concerned, over anybody else’s will, while the proxy can be a spouse or a partner or one the of the closest relatives or even a close friend.

In the second case regarding “living wills”, the wish of the person concerned usually excludes certain painful medical or palliative acts (such as artificial feeding or hydration of the organism), which is generally equal to refusal of (further) treatment and cessation of life prolongation.

"Do-not-Resuscitate Orders" are a typical case of exclusion of the medical act; by these orders, the person who may suffer a cardiac arrest, regardless of the etiology, refuses cardiopulmonary resuscitation. The latter presupposes the immediate intervention in the chest area (by means of compressions or mechanical means) and its eventuality intimidates the average patient.

In Europe, the frequency of the occurrence of cardiac arrest is estimated at an annual rate of 0.4-1%, concerning 350,000 to 700,000 patients.[1] It is worth noting that the critical time for resuscitation is minimum (4 minutes) in order to avoid causing neurological damage to the patient due to the lack of perfusion to the brain. In case a time of 10-12 minutes upon cardiac arrest lapses without an act of resuscitation, death is inevitable. Therefore, cardiac arrest produces *de facto* circumstances of emergency. Attempts of cardiopulmonary resuscitation are unsuccessful in most cases (70-98%), while there are not sufficient data and established criteria so as to make a safe prognosis of the outcome.[2]

From an ethical standpoint, advance directives (and more specifically, "Do-not-Resuscitate Orders") aim at exploring the individual's autonomy in health issues. In their sense, anybody can make valid decisions about his/her medical treatment, even while not suffering from a particular disease or even if these decisions simply concern eventual medical acts. The decisions in question, made at one point (excluding neurodegenerative diseases, where one can predict with relevant certainty permanent loss of the person's consciousness), are considered binding, even if the patient who is incapable of expressing his/her own will may, in the meantime, change his/her mind. In this regard, that is, supporters of the directives weigh the explicit expression of will by the person concerned him/herself more important than the "valid nature" of this will, notwithstanding the above risk.

2. The legislation

The institutional recognition of advance directives constitutes a global cause for concern. In certain EU countries (Germany, Spain, the Netherlands, etc.) a relevant legislation is already in place, as is the case in some US States, where

[1] Sans S, Kesteloot H, Kromhout D (1997). The burden of cardiovascular diseases mortality in Europe. Task Force of the European Society of Cardiology on Cardiovascular Mortality and Morbidity Statistics in Europe. Eur Heart J; 18(12):1231-48.

[2] Lippert FK, Raffay V, Georgiou M, Steen PA, Bossaert L (2010). European Resuscitation Council Guidelines for Resuscitation 2010 Section 10. The ethics of resuscitation and end-of-life decisions. Resuscitation; 81(10):1445-51.

hospitals specifically apply "Do-not-Resuscitate Orders". The issues addressed, in this respect, are the extent of the period the will is valid on the one hand (as described above) and the certification of its authenticity, which presupposes the adoption of a formal process (e.g. a notarial act, the presence of testimonies, opening a separate file to which the attending physician must be guaranteed direct access, etc.).

In the Greek law, advance directives are only mentioned in Article 9 of the Oviedo Convention (Law 2619/1998), pursuant to which they “shall be taken into account”. This wording creates confusion regarding their binding nature, for both the physician and the relatives and, therefore, constitutes an incomplete recognition of the directives.

According to the Code of Medical Ethics (Article 12 of Law 3418/2005), in case the patient him/herself is incapable of consenting to a medical act, the relevant decision is made by his/her relatives. According to the same article, the physician may act without consent only in cases of emergency. Besides, pursuant to Article 29 of the Code, the physician is justified in focusing his/her attention on palliative care (in essence, accepting the eventuality of death, whenever it comes), only in case the continuation of the treatment provided is “futile”.

Pursuant to the above, once an incident of cardiopulmonary arrest is treated, for which cardiopulmonary resuscitation is deemed appropriate, the physician does not need the relatives’ consent in principle, since there are circumstances of emergency.

Moreover, the physician cannot “take into account” any current “Do-not-Resuscitate Order” on behalf of the patient except for the case where he/she deems that resuscitation equals “futile treatment”. If, on the contrary, resuscitation has a permanent therapeutic benefit for the patient, the physician’s compliance with the former’s previous wish would violate the fundamental duty of protecting the life of the patient, always pursuant to current law.

Therefore, the question further posed is whether this limited importance of the directives is reconciled, from an ethical and social standpoint now, with the

individual's autonomy in health issues. Once the answer is negative, the legislator will then need to specially provide the recognition of the directives.

3. Recommendations

The Commission holds that advance directives relate, by definition, to the individual's autonomy in health issues indeed, and shall therefore not be overlooked in relevant medical decisions, once the patient him/herself is incapable of expressing his/her own will at the critical time.

One shall not namely overlook that the wording of such directives generally includes guarantees of severity, especially when it is pursuant to a particular promulgated process and it is not informal.

The eventuality that the person concerned changes his/her mind at the critical time obviously exists, but it does not suffice to lift the binding nature of the directives. Besides, the same eventuality - and maybe even more so – applies when the patient is legally represented by his/her relatives. Here, as well, the patient may have another opinion but he/she is incapable of expressing it, while relatives may decide on the basis of criteria which are different from the ones adopted by the patient or even imposed by his/her objective interest.

The Commission reiterates, thus, its previous position on the recognition of advance directives by the legislator, namely in the form of the concerned person choosing a specific person of trust, who shall act as his/her proxy in issues of medical decisions.

Particularly, the case of "Do-not-Resuscitate Orders" nonetheless demonstrates two particularities: the fact that it concerns circumstances of urgent medical intervention (during which patient autonomy is *de facto* limited) and that it constitutes an extreme form of refusal to treatment given that death is inevitable.

The Commission deems, in this respect, that the institutional recognition of advance directives presents certain serious risks. Apart from the obvious technical difficulties of locating the directives in question at the minimum time during particular urgent incidents (where the physician or, possibly, a simple carer of the patient will have to act within a few short minutes, often without the possibility of direct communication), chances that the patient, who is incapable of expressing him/herself, changes his/her mind are stronger in this case, given the inevitability of death.

One shall not overlook that cardiac arrest is not proportionate to more permanent states of suffering and pain caused by incurable diseases, namely at a terminal stage, when death can constitute a reasonable wish for the patient. At this point, the restoration of cardiac function, painful as it may be, has nevertheless a therapeutic purpose: the patient does not experience the pain and suffering caused by the same disease at its terminal stage until the patient passes away.

In conclusion, the Commission deems that the importance of "Do-not-Resuscitate Orders" is meaningful only when the attending physician deems that resuscitation shall not have a more permanent outcome; it shall constitute, that is, “futile” treatment. It is in this last case only that the physician -acting, either way, without the need for third parties’ consent in circumstances of emergency- if he/she is in a position to have certainty over the existence of such directive on behalf of the patient, must consider him/herself bound and must not proceed to the restoration of cardiac function.

In any other case, the Commission deems that "Do-not-Resuscitate Orders” shall not influence the physician’s decision. The same applies, even more so for any carer who is not a physician (nurse or other), given that his/her training does not even allow for the evaluation of the futile or not nature of the particular intervention.

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