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Medicolegal Bioethics Study Regarding Refusal of Cardio Pulmonary Resuscitation Stated in the Do-Not-Resuscitate Form

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***Abstract*— One form of medical action that the patient has the potential to refuse is cardiopulmonary resuscitation (CPR). If a patient has the right to refuse CPR, does this mean that the statement "Do-Not-Resuscitate" (DNR) is the same as euthanasia? This is an empiric juridical research and aims to identify regulations related to patient DNR consent as a form of refusal to CPR. The DNR still requires a more in-depth study of various related aspects, including (but not limited to) legal, religious, social, culture, medical, technology, and bioethics. The understanding related to "death" and its relation to human rights to live and determine their life is also a consideration in thinking about DNR regarding this CPR. Aspects of communication and documentation of DNR results against CPR (if so decided) also need to be carefully planned.**

Keywords—do-not-resuscitate, medical record, euthanasia, cardiopulmonary resuscitation, death

I. INTRODUCTION

Discussions about stopping medical life-support assistance began to be widely discussed after the case of Karen Ann Quinlan, a 21-year-old woman from New Jersey, United States, who in April 1975 lost consciousness and was hospitalized with a respirator. Apart from the respirator, Quinlan was also fitted with an IV tube to insert intravenous food. Quinlan's condition lasted for five months and finally the doctor who treated him declared a persistent vegetative state (permanent coma). With this condition and based on the feeling of reluctance to the child's suffering and the belief that there is no chance for their child to regain consciousness and recover, Quinlan's parents asked the treating doctor to stop using medical equipment for their child, but the doctor refused this request. This case was later brought to court and rejected at the court of first instance, but was granted on appeal. Finally on the basis of this court decision, all medical aids were released in March 1976. [1,2,3]

One form of medical action that the patient or the patient's family has the potential to refuse is cardiopulmonary resuscitation (CPR). The decision to perform CPR is often sudden and urgent and medical personnel may not have time to check or do not know whether or not there are advanced directives statements from patients in their medical records. Advanced directive is a legal document created while the patient is still competent. An advanced directive is a patient's statement about his decision regarding what medical actions are allowed and not allowed to be performed by doctors on him. [4,5,6]

Several studies from a medical, ethical, moral, and legal point of view trying to formulate a decision to end the patient's life are very similar to euthanasia but not euthanasia. Leenen called this case Pseudo-euthanasia and not legally euthanasia. The form of pseudo-euthanasia which is actually quite common is the patient's refusal to plan medical action (against medical advice) which is manifested in the form of a statement as Informed Refusal. [7]

In practice, after receiving an adequate explanation, a competent patient has the right to determine whether or not he is willing to accept the described medical action plan. [8]

If the medical plan is part of a plan to save a patient's life or an effort to extend the patient's life, does that mean that the patient is deemed entitled to also reject the medical plan and choose to "discontinue his life"? If the patient can choose to stop medical efforts, does that mean that the patient is allowed to be euthanized? If a patient has the right to ask not to take life-saving medical action against him, does this mean that the statement "Do-Not-Resuscitate" is the same as euthanasia?

With these various considerations in mind, it is necessary to conduct research to examine the bioethical aspects of medicolegal on the statement "do-not-resuscitate" as a form of refusal of CPR.

II. PROBLEMS

How is the medicolegal bioethics study on the statement "do-not-resuscitate" as a form of refusal to cardiopulmonary resuscitation (CPR)?

III. RESEARCH METHOD

This study is an empirical juridical study and aims to identify regulations related directly or indirectly to patients' statements to refuse CPR through the "do-not-resuscitate" form. The research was conducted by reading and examining various regulations related to the problems in this study and formulating the results qualitatively.

IV. DISCUSSION

A. The Basic of Bioethics and Their Relation to CPR

In general, the four ethical principles (beneficence, non-maleficence, autonomy, and justice) can be accepted across cultures, but can vary from culture to culture. [9]

There are 4 principles related to bioethics that should always be taken into account in the consideration of problems related to bioethics medicolegal, namely:

1) Beneficence, namely the principle that a doctor must do good, respect human dignity, and must try his best to keep his patient in a healthy condition. The main point of the principle of beneficence actually emphasizes that a doctor must take steps or actions that have more good effects than bad so that the patient gets the highest satisfaction. [10]

The principle of beneficence in CPR is restoring health and its functions and relieving pain and suffering. Elective resuscitation performed in the 1940s and early 1950s in intensive respiratory care increased the life expectancy of bulbar polyomyelitis disease from 15% to over 50%. A decade later, 14 of the 20 patients (70%) treated with closed heart pulmonary massage survived. Kouwenhoven et al reported that the discharge rate for patients at John Hopskins Hospital was around 14% in 1985, and below 10% in 1994. A success rate of about 70% has never been published. The greatest advantages of CPR, with a greater than 20% chance of survival, have been reported in cardiac arrest during anesthesia, drug overdose, and primary coronary heart disease or ventricular arrhythmias.

In 1995 the discharge rate was only about 17%, which was followed by the implementation of CPR on patients in an integrated coronary heart unit monitored by trained personnel. Rarely do patients survive CPR in which cardiac arrest is caused by a disease other than the heart or organ dysfunction. The life expectancy of patients after CPR is very poor (<5%) when cardiac arrest occurs in patients with renal failure, cancer (except those with minimal disease), or AIDS; and in the absence of irreversible causative disease, followed by trauma, bleeding, prolonged hypotension or pneumonia.

Restricted implementation of CPR has increased the patient's life expectancy by 10.5% after CPR while another 7-10% were detained for CPR. Rapidly initiated CPR in Seattle resulted in a life expectancy of 36%, the highest achieved of any data currently available in the literature. In traffic areas where there is a worse system, it will take great effort to change it. Specifically, in the cities of New York and Chicago the life expectancy after CPR was less than 2%, this was due to the late initiation of CPR due to heavy traffic. Age is not a contraindication to CPR.

Although it is said that the aging process is associated with the accumulation of various weaknesses and diseases where there is long-term treatment and decreased body function, it is still one predictor of poor CPR results. [11]

2) Non-maleficence, which is the principle in which a doctor should not take an action or action that can worsen the patient's condition. So, doctors must consider and choose the procedure with the least risk. The concept of "do no harm" is at the heart of the principle of non-maleficence and this principle can also be applied to emergency or emergency situations. [12]

The rate of brain damage associated with CPR varies between 10-83%. In one study, 55 out of 60 children died from prolonged CPR; The five children survived in a persistent coma condition or vegetative status at the time of hospitalization. Many patients with severe disabilities followed by brain damage are in the same condition as death. CPR is dangerous and destructive when the risk of brain damage is relatively high. Since disruption of blood flow to the brain or to the heart can cause serious damage, CPR can be considered successful only if it is performed on time.

An investigator from Sweden reported that life expectancy exceeds 80% when the person around the victim is given CPR and the ambulance arrives in less than 2 minutes, but this figure is even worse than 6% when the ambulance arrives for more than 6 minutes or no one is around. the victim who performed CPR. In some countries in the United States, although emergency personnel have restricted the use of CPR in the field, there is still evidence that CPR is not desirable. In fact, 7% of patients discharged from the hospital did not want CPR to be performed. CPR action is said to be harmless if the benefits are greater. [13]

3) Autonomy, which is the principle by which a doctor is obliged to respect human dignity and rights, especially the right to self-determination. Related to this, the patient must get the right to think logically and make decisions according to his wishes. Besides being respected ethically, autonomy is legally respected. In terms of autonomy, the patient referred to here is a patient who is able to communicate, adult, can consider approving or rejecting a medical action plan. [14]

Patient autonomy must be respected ethically and in most countries legally respected. However, this requires a patient who can communicate to be able to approve or reject medical procedures, including CPR. In the United States, adult patients are considered to have decision-making capacity unless a court has determined that they are not competent to make medical action decisions whereas in other countries court decisions are not required for patients with incompetency such as those with mental illness. [12,13,15]

Informed consent requires that patients can receive and understand accurate information about their condition and prognosis, the type of medical action proposed, other alternative measures, the risks and benefits of these medical procedures. Patients must also be assessed for their capacity to make decisions. If the patient is in doubt then he must be considered to have the capacity, and if the capacity to make this decision is disturbed by drugs, comorbidities, then the patient's capacity must be returned first. In an emergency, where patient preferences may be uncertain, with limited time to make decisions it is wise to provide standard medical care. Patients usually don't have a plan for what happens at the end of life (end of life), many do not want to prepare advanced directives, living wills (wills) or discuss CPR. Doctors also rarely discuss these matters with their patients, even if the patient is seriously ill. Many patients have a vague understanding of CPR and its consequences.

The general public hopes a lot about the possibility of surviving a heart attack. Some sufferers may refuse to undergo CPR because they are aware of the severe sensory deficits that

develop after the attack. However, many studies on the quality of life of heart attack survivors suggest that this risk is acceptable. Both doctors and sufferers may have different perceptions about quality of life. The doctor has an obligation to explain to patients about CPR and the results of resuscitation. Correct decision making can occur when the patient has a good understanding of the perceptions and outcomes of resuscitation. Later problems can arise because many doctors cannot accurately predict the survival rate of a heart attack. So that sufferers cannot be forced to take consent about CPR.

Both Kant and Rawls say an autonomous moral decision must be rational and impartial to any one decision maker. Rawls makes it clear that decision makers, voters, do not know their future in a community. From this principle the experts conclude that the patient must be able to determine his own treatment. This principle requires that we review and solve two problems. First, the patient always thinks about the outcome of the decision on the medical action, therefore it does not always have to be based on the principle of autonomy even when the decision about the medical action cannot relieve pain or suffering. Second, it is the principle of justice that produces the ability to accept something, not autonomy. In their latest formulation Beuchamp and Childress more accurately describe this principle as "respect for autonomy". There is some evidence that a surrogate caregiver, in whom he or she acts on behalf of the patient when the patient has lost his decision-making capacity, turns out that the patient is unable to properly convey his true desires. About one third of chronic kidney patients accept decisions made by a surrogate guardian, even if the decision is against his will. [3,12,13]

4) Justice, which is the principle whereby a doctor is obliged to treat his patients fairly, without discrimination based on ethnicity, race, religion, economic level, social position, and so on.

Thinking about the principle of justice includes the creation of rights to receive something, competition for personal gain and balancing social goals. The problem is that a moral value of justice should be needed to provide medical care to those who need it with beneficial effects, because justice is needed to reduce the inequality in treatment that often arises in society. Doctors must adjust to community sources of income to treat them based on generally provided sources of income such as from private insurance, or government or direct institutional support.

However, to determine whether a value of moral justice is needed for the minimum feasibility of providing medical services for this purpose, it must be assessed how important the problem at hand is, therefore it is proposed that basic health services should: (1) prevent, treat, and seek one-year survival more than 75 percent (2) resulted in less toxicity or long-term disability (3) was beneficial and (4) was significantly more beneficial than damaging. [9]

B. Ethics at the End of Life

At the end of the patient's life, conditions may arise that trigger questions to be decided, for example "is it okay to stop nutritional and fluid therapy for the patient?", Or for example, "to what extent the family is involved in making decisions regarding medical treatment for the patient?" Related to this condition, there was also an issue about physician assisted suicide, physician assisted death, letting die naturally, euthanasia, futility, and brain death.

Likewise, cardiopulmonary resuscitation (CPR) was initially only intended to help with acute and reversible cardiac arrest conditions. However, in its current development, CPR is almost always performed in every cardiac arrest condition. Even in a layman's sense, CPR is considered a routine measure to save patients with cardiac arrest.

The Indonesian Doctors Association (IDI) has issued a statement that allows end-of-life decision in Indonesia by considering various aspects. In the condition of facing a patient who is assessed as having no life expectancy, there are two options, namely with-holding or with drawing life supports, namely delaying or stopping life support devices. The Indonesian Doctors Association (IDI) issued a statement in 1990 that humans would be declared dead if their brainstem was no longer functioning. This concept is used as an official statement from the Indonesian Doctors Association. The criteria adopted by the Indonesian Doctors Association (IDI) are based on the reason that the brain stem is located in the driving center of the breath and heart. When the brain stem has died, the heart and lungs can only move with the help of supporting tools (Haryadi, 2007).

C. Do-Not_Resuscitate (DNR)

1) Definition, DNR or do-not-resuscitate is an order that tells medical personnel not to perform CPR. This means that doctors, nurses, and emergency medical personnel will not attempt emergency CPR if the patient's breathing or heart stops.

2) History of DNR, The DNR order has been in use for about two decades. The arguments for the use of DNR include increasing patient autonomy, avoiding futile medical interventions, and the cost of hospitalization. Numerous studies have shown that in certain clinical situations, CPR is almost always futile. The doctor's job is to communicate both his knowledge of both the likelihood of what happens, and the results that can be achieved from CPR to the patient and patient's family and then to assist the patient or patient's family in making decisions about this resuscitation. The key to this process is early action, effective communication between the doctor, patient and patient's family. In the United States, the American Medical Association first recommended that the decision to perform resuscitation be formally documented and communicated. It was also emphasized that CPR was intended for the prevention of (sudden / terminal) death, that explicit DNR policies were immediately followed, and that the patient's right to self-determination was promoted. At the root of the debate, it was assumed that patients would always choose resuscitation, and that anything to the contrary required their explicit consent. Critics question such an approach and argue that CPR is never intended in all situations, therefore CPR is only offered to those who are medically indicated. However, in 1983, the presidential commission for the study of ethical issues in medicine disagreed, resuscitation attempts were undertaken in almost all cases, and patients were deemed to have made implicit consent for CPR. Thus, CPR became the standard of

care. DNR orders are then applied in all hospital environments.

3) Indications and Contraindications for DNR, The decision to write a DNR order must be based on two important considerations. The first is an assessment that CPR will be very unlikely to succeed in restoring a normal heart rhythm. Both are based on patient preferences, As expressed by either patient or surrogate. Patient preferences often reflect their own assessment of their own quality of life. These two aspects must be assessed in any decision to write a DNR order. All persons who suffer unexpected cardiorespiratory arrest should undergo CPR, except: the patient has a DNR order, there is convincing evidence that the patient is dead, e.g rigor mortis, no physiological benefit can be expected because vital function has deteriorated despite maximal therapy for conditions such as cardiogenic shock.

V. CONCLUSION

The statement of the patient or patient's guardian regarding the rejection of the cardiopulmonary resuscitation (CPR) action plan as outlined in the form of "Do-Not-Resuscitation" (DNR) still requires a more in-depth study of various related aspects, including (but not limited to) legal, religious, social, culture, medical, technology, and bioethics.

The understanding related to "death" and its relation to human rights to live and determine their life is also a consideration in thinking about DNR regarding this CPR. Aspects of communication and documentation of DNR results against CPR (if so decided) also need to be carefully planned regarding the form of documentation, the content, grammar, and validity.

REFERENCES

[1] "The Big Sleep Karen Ann Quinlan". Available at: http://content.time.com/time/specials/packages/article/0,28804,1864940_1864939_1864909,00.html. Accessed 08/29/2020.

[2] Ashish R. Panchal, et.al, Focused Update on Advanced Cardiovascular Life Support: Use of Advanced Airways, Vasopressors, and Extracorporeal Cardiopulmonary Resuscitation During Cardiac Arrest., An Update to J.AHA Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care., Vol. 140., Issue 24. December 10, 2019., Available at: https://www.ahajournals.org/doi/10.1161/CIR.0000000000000732., Accessed 08/29/2020.

[3] Beauchamp TL, Childress JF, Principles of biomedikal ethics [4thed], New York: Oxford University Press, 1994.

[4] Department of Health, Western Australia, Advance Care Planning: A patient's guide, Perth: WA Cancer and Palliative Care Network, Department of Health, Western Australia; 2017.

[5] Ethical Aspects of CPR and ECC. J.AHA Vol 102, Issue suppl_1, August 22, 2000 (Originally published22 Mar 2018), Available at: https://www.ahajournals.org/doi/full/10.1161/circ.102.suppl_1.i-12, Accessed 08/29/2020.

[6] Fine, Robert L, From Quinlan to Schiavo: Medical, Ethical, and Legal Issues in Severe Brain Injury, BUMC Proceeding 2005; 18:303-10.

[7] Fred Ameln. Kapita Selekta Hukum Kedokteran, Jakarta: Grafikatama Jaya, 1991, pp.140.

[8] Hanafiah, Jusuf., Amir, Amri. Etika Kedokteran & Hukum Kesehatan, edisi 4. Jakarta: EGC, 2007.

[9] Hilberman M, Kutner J, Parsons D, Murphy DJ. Marginally effective medikal care: ethical analysis of issues in cardiopulmonary resuscitation (CPR). Journal of Medical Ethics 1997;23:361–7.

[10] Matter of Quinlan. Available at: https://practicalbioethics.org/case-studies-study-guide-matter-of-quinlan.html, Accessed 08/29/2020.

[11] Pantilat, S. Beneficence vs. Nonmaleficence, The Principle of Beneficence, In: Applied Ethics from Crocker, D. A., Ethics of Global Development: Agency, Capability, and Deliberative Democracy, Cambridge, Cambridge University Press. http://plato.stanford.edu/entries/principle-beneficence/. 2008.

[12] Part 2: Ethical Aspects of CPR and ECC. ECC Guidelines. Circulation. 2000;102(suppl I):I-12–I-21.

[13] Part 2: Ethical Issues, American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, Journal of American Heart Association Circulation 2005;112;IV-6-IV-11.

[14] Regulation of the Minister of Health number 290 / Menkes / Per / III / 2008 concerning Approval of Medical Action.

[15] Sachrowardi, Qomariyah S., Ferryal Basbeth, Bioetika : Isu & Dilema. Jakarta :Pensil, 2011