

An Islamic Medical and Legal Prospective Of Do Not Resuscitate Order In Critical Care Medicine

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Abstract

Background:

Autonomy is respected in all medical management. Competent patient may give informed consent, but incompetent patients like children or unconscious adult patients need the informed consent of their guardians or surrogate managers. A well informed competent patient has decision-making capacity; it is generally, in all societies, has the right to refuse medical therapy, including treatment that will sustain life artificially. During critical illnesses and in case of sustained coma such decision would be taken on his behalf by physicians and or next of kin or a manager that are following his advance directive. If the patient has made a decision to receive life-sustaining therapy, or if circumstances have arisen in which such therapies were initiated, the patient is free, supposedly, at any time to decide whether to have such treatments continue or be withdrawn. There are legal, economical and ethical issues governing such decision, all physicians would support the right to live. But the right to die is not well defined or accepted in most societies. In Islamic societies euthanasia and assisted suicides are forbidden. But the wishes of patient not to have his dying prolonged artificially with the presence of hopeless prognosis are well preserved. Such wishes may be declared in advance directive or accepted standing Do Not Resuscitate (DNR) order in certain hopeless medical conditions. There is no relevant distinction between withholding and withdrawing life-sustaining treatment. In this paper summarized (ICU) current practice in intensive care unit regarding initiating DNR order and Islamic advance directive sample for managing dying process in dignity.

Setting:

Literature review

Method:

A search of regional and international literature documents regarding policy and procedures was conducted to elicit current practice medical and legal guidelines for DNR order practices in Arabic and Islamic ICU units in the last months of year 2007

Results:

There were 138 books and articles dealing with the general key words Do Not Resuscitate order in Google scholar 32 were relevant to guidelines. 12 articles were dealing with research and one leading article death with the issue of no-code as guidelines incorporated in optimizing the use of ICU in Saudi Arabia. Other guidelines by medical assembly of North America Ethical Committee addressed the issue in details and in suggestion way as such guidelines do not get the same weight of the fatwa or Verdict of religious scholar

Conclusion:

The general consensus was that the issue of end of life in Muslim societies is still evolving. There is great respect to human life and the exciting civil forbids euthanasia or assisted suicide, in regards other issues like brain death and DNR The Islamic Verdicts were facilitating the easy courses of medical futility decided by competent doctors.

INTRODUCTION

Muslims believe that death as depicted in Qur'an:

“Every soul shall have a taste of death”.[₁]

There is another doctrine every Muslim submits to: “No soul dies except by Allah permission” [₂]. The other doctrine

Muslim submits to that only God [Allah] who determines life and death of a man.

The life of human being in Islam is sacred and nobody on Earth can end it except in situations of punishing somebody purposely committing murder or spreading mischief on Earth.

“... If somebody killed a person, unless it is for murder or spreading mischief on Earth, it would be as if he killed all of mankind. And if anyone saved a life it would be as if he saved the lives of all mankind ...” [3].

So; How Muslim manages the new development regarding end-of-life issues? He is urged according to his faith to preserve his life and His doctor is urged to preserve life of mankind. The decision to withhold life support from a patient within the intensive care unit (ICU) is modern medico-legal issue. It goes into many forms:

Organ donation and the issue of brain death.

Euthanasia and “Mercy Killing”

Do-Not-Resuscitate (DNR) orders called some time Do-Not-Attempt-Resuscitation (DNAR) or No-Code (NC).

These issues have been encountered in all modern societies. Many papers in the international literature were written about its aspects.

They are generally governed by many crucial factors; ethical, legal, economical and social. These factors can influence the final decision. The various solutions and final decisions were reflection of patient views, religious views, legal views and futility views.

METHOD

Do not resuscitate order Islamic, Google Scholar and PubMed search

A search of regional and international literature documents regarding policy and procedures guidelines was conducted to elicit current practice medical and legal guidelines for DNR order practices in Arabic and Islamic ICU units in the last months of year 2007.

RESULTS

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Other guidelines by medical assembly of North America Ethical Committee addressed the issue in details and in suggestion way as such guidelines do not get the same weight of the fatwa or Verdict of religious scholar

DISCUSSION

[1] DNR in Islamic society

Withholding Medical therapy at the end of life has now been widely accepted in many countries around the world on medical, legal, ethical, and moral grounds [4].

The Islamic religions concepts concerning DNR decision have been clarified by the Presidency of the Administration of Islamic Research and Ifta, Riyadh, KSA, in their Fatwa No. 12086 issued on 30.6.1409(Hijra) [1988 (AD)]. The Fatwa [5] states that: “if three knowledgeable and trustworthy physicians agreed that the patient condition is hopeless; the life-supporting machines can be withheld or withdrawn. The family members' opinion is not included in decision making as they are unqualified to make such decisions”.

Based on the above Fatwa, Many hospitals in Saudi Arabia have implemented a “No Code” policy {Appendix-(1)}. The policy states that: (“No Code” status is applied after agreement of three physicians, two of whom at least are consultants. The family members will be informed about the decision. In case of conflict with the family, arrangements to transfer care to another facility may be made. The policy had led to a dramatic reduction in futile CPR. In fact, DNR orders are written currently for 66% of patients who die in ICU and 82% of patients who die in the wards [6]. However, there is still a great variability in DNR practices. For example, DNR orders are more likely to be written on day one of hospitalization in cancer patients and on the last hospital day in cirrhotic patients, underscoring the delays in recognizing the futility of the treatment in some patients [6].

A decision on DNR, particularly early in the hospital stay, can bring about significant resource use reduction for an identifiable group of patients [7]. Identifying these patients early and carefully evaluating them based on objective and well-validated criteria would allow conducting therapeutic limits reducing unnecessary patient suffering and medical care costs. CPR should only be performed on patients, who

are likely to benefit from it. Similarly, admission to ICU should be offered only to patients who are likely to benefit from the admission.[American Thoracic Society. Fair allocation of intensive care unit resources [8]. Avoidance of unnecessary admissions to ICU can lead to substantial saving of resources as one day stay on the ward costs only a 6th of that in the ICU [8,9]. Approaches to address this sensitive matter may include the following: (i) Raising the awareness among people, particularly physicians, on the limitations of aggressive life support. As it is important for the physician to recognize when to provide a therapy, it is of the same importance to recognize when to withhold therapy. Admission to the ICU and the provision of aggressive life support, including cardio-pulmonary resuscitation, should be reviewed as a treatment. Patients may or may not be candidates for this treatment. While failure to provide a proper therapy is considered negligence, improper utilization of the ICU should be considered an abuse of this important resource. Needless to say that not all patients have to be admitted in the ICU for dying; the ICU is not “dying place” but rather an area where life supports is provided to patients with reasonable chance of recovery. Raising the public and physicians awareness can be accomplished by utilizing the media as well as the medical and health education programs, and organizing seminars on the end of life issues. More emphasis has to be placed on end-of-life issues in the curriculum of medical students and the residents.[10] (ii) The practical application of DNR policy is unlikely to succeed without administrative support and enforcement.

[2] Islamic medical assembly of North America's guidelines.

Muslims living in non Muslim Countries.

Islamic Medical Assembly of North America (IMANA) made some interesting guidelines for many Ethical many ethical and medical issues through (ISLAMIC MEDICAL ETHICS) which produce a document called (The IMANA Perspective) [11]. This document incorporated the status of law in North America and the right of competent patient to decide for himself the status of DNR and to write advance directive for his surrogate to follow his will. Appendix [2]. This is a very serious trial tied to justify and help Muslims living in America to exist in harmony with their new society. It is highlighted by this justifications and raised questions: The DNR issue background stem from the high expenses of maintaining modern medical care of terminally ill patient. It is very expensive to keep a patient with terminal cancer or vegetative state condition in intensive care unit. The

question currently asked is Who determines that the life support should be stopped? Is it the doctor? Is it the family or the condition of unconscious patient?

What is the definition of death? Is withholding the support system a crime or act of human nature, or purely medical issue? Does or should financial factor play a role in the decision-making?

[3] The Civil law legal stand on the end of life issue

Arabic countries laws as in most countries do not support the concept of assisted suicide or mercy killing or Euthanasia. Any physician who engages in such process would be subjected to legal proceeding on account of murder. The issue of DNR is not fully distinct and it was left to physicians' choices and preferences. The family and society would monitor such divisions and may need lengthy discussion.

CONCLUSION

The general consensus was that the issue of end of life in Muslim societies is still evolving. There is great respect to human life and the exciting civil forbids euthanasia or assisted suicide, in regards other issues like brain death and DNR The Islamic Verdicts were facilitating the easy courses of medical futility decided by competent doctors.

DEFINITIONS

Figure 1

DNR	Do Not Resuscitate
DNAR	Do Not Attempt Resuscitation
CFR	cardiopulmonary resuscitation
Patient Autonomy	Patient's ability to decide independently on issues of life or death
Advance Directive	Living will generally but in relation to DNR situation it should document the patient views. While he is competent to give such living will, regarding the decision relating to not to resuscitate indefinitely whatever the results are poor. It should be witnessed document by two witnesses nominating a surrogate to see it done when the patient is incompetent to take decision. It should be authenticated and registered legally.
ICU	Intensive Care Unit

APPENDIX [1] LOCAL HOSPITAL DNR POLICY AND PROCEDURES []

OBJECTIVES:

1. This Policy shall delineate the meaning and scope of DNR order.
2. This Policy shall determine the patient's condition in which DNR order is applicable.

3. This Policy shall determine who decide and approve the DNR order.

The committee would like to stipulate the difference between the Basic Life Support which can not be denied at any time for patient from the Advanced Life Support (ventilation support or invasive medications).

Finally, the Committee tried their best to achieve the following guidelines of resuscitation or not to resuscitate order for adults, children and neonates. We ask God for guidance and help during this task and we hope that we have fulfilled and achieve the right conclusions.

APPLICABILITY:

This policy shall apply to all adults and pediatric wards including the various Intensive Care Units (ICUs).

POLICY:

Coding for resuscitation including cardio respiratory resuscitation (CPR) shall be applied to victims of sudden cardiac or respiratory arrest with reversible causes in whom the treatment carries a reasonable possibility of remission of symptoms and restoration of the patient toward an acceptable functioning integrated existence, not biological vegetative existence.[LIST ONE]

These conditions include: Drowning and near drowning – Suffocation, Electric shock, Lightning, Untoward, effects of drugs, Anesthetic accidents, Heart block and malignant arrhythmias, Acute myocardial infarction Trauma, Surgical complications

In case of doubt, the principle of “act first and evaluate later” should be applied.

DNR should be considered: if it offers no potential benefit in patient with poor quality of life before cardio respiratory arrest, e.g.:

- a. severe mental or physical incapacity.
- b. terminal or untreatable chronic diseases which are associated with extremely low chance of survival such as:
 - Cancer
 - Multi organ failure
 - known severe brain damage or brain death
 - advanced pulmonary diseases

- Conditions which are associated with extremely low chance of survival for example:
 - Inoperable congenital heart disease.
 - Werdnig Hoffman disease Spinal muscular atrophy type-one
 - Fatal Chromosomal anomalies
 - Fatal neuromuscular diseases.

PROCEDURE:

It is important to identify all critically ill patients and whose condition which can become potentially so, in those whom CPR is inappropriate. This is the responsibility of caring team led by the consultant.

The caring physician must notify the DNR Committee of his department. All member plus the attending physician must agree on considering that the DNR is applicable for this patient.

In case of delayed report by the attending physician, the matter should be raised by the division supervisor.

Where CPR has no potential benefit, at least 2 consult physicians (both Muslim) must agree on the diagnosis of a clear cut situation or in case of ample documented medical evidences plus family approval.

Once appropriate agreement is achieved, the family must be informed, in order to obtain full approval. It is the responsibility of the attending consultant physician caring for the case (once eligible for DNR) who should discuss the patient condition in details with the parents or relatives with special emphasis directed to the following issues:

- The natural history of the disease.
- The quality of the life of the patient if CPR is done.
- The possible effects of such situation on the patient himself, his siblings and the family unity.
- The parents should be informed that the decision about DNR is a medical decision.
- The parents should be encouraged to share the decision or give unrestricted agreement to the medical decisions.

If approval is obtained DNR order shall be written on the patient's note and the appropriate DNR form to be used.

If advanced life support has been provided, start to withdraw the order

If advanced life support not started yet withhold them.

If there is any uncertainty in the minds of the treating physicians or disagreement between them and the patient or his relatives, the final decision is for the DNR Committee. The family has nothing to say in the DNR decision. Reference to the fatwa No.12086 dated 30/6/1409H. In this context the relative can raise the matter to the Chief of Staff.

In the case of an emergency in which the antecedent state is uncertain, the principle, "Act first and evaluate later" shall prevail.

DNR decision shall not of itself preclude the continuation of basic treatment. The jurisdiction to discontinue other medical treatments and life requirements shall be decided upon specifically and separately from DNR orders.

APPENDIX [2] (SAMPLE) ADVANCE DIRECTIVE (LIVING WILL)

Declaration made this _____ day of _____, 20____, _____, a Muslim of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below and I declare: If at any time I have an incurable injury, disease or illness certified in writing to be a terminal condition by my attending physician(s), and my attending physician has determined that the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and

that I be permitted to die naturally with only the provision of appropriate nutrition and hydration and the administration of essential medications and the performances of any medical procedures necessary (as determined by my physician) to provide me with comfort or to alleviate pain.

In the absence of my ability to give direction regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal.

_____ is my case manager to enforce my living

will, if I am not physically able to give direction. I do not permit autopsy of my body unless my death occurred in a suspicious manner and it is important to know the cause of death or if it is required by the court of law. It is my desire that Muslims attending my dying process ensure that Islamic Shari'ah is practiced during preparation of

my body for burial and that my body be treated with grace and privacy and buried with Islamic

guidelines under the directions of my Muslim family, Imam or other qualified Muslims as soon as it is feasible.

Signed _____ Date _____

Place _____

The declaring person has been personally known to me and I believe (him/her) to be of sound mind.

I did not sign the declaring person's signature above for or at the direction of the declaring person. I am not a parent, spouse, or child of the declaring person. I am not entitled to any part of the declaring person's estate or directly financially responsible for his/her medical care. I am competent and at least eighteen (18) years of age.

Witness (to the document) _____

Date _____

Witness (second) _____

Date _____

CORRESPONDENCE TO

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Chair Hossam E. Fadel, MD, Vice-Chair. Members: Wahaj D. Ahmed, MD. Abdul R.C. Amine, MD. Malika Haque, MD. Farouque A. Khan, MD. Hussain F. Nagamia, MD. Hasan Shanawani, MD. Hassan Hathout, MD, PhD (advisor)

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