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Introduction:


Modern health facilities are available at hand to provide the best care for trauma patients as well as patients who are critically ill, have advanced disease or cancer. Today a higher percentage of these patients will end up in ICUs and a good proportion of these are likely to have a prolonged ICU stay. As ICUs developed and Critical Care Medicine matures in to a recognized subspecialty, it became clear that ethical decision making concerning withholding and withdrawing life support presents major dilemma. This policy aims to make decision making in the ICU less daunting.

1.0 Purpose:

Establishing a policy and procedure concerned with the determination of Do Not Resuscitate (DNR) status for adults, pediatrics and neonate patients that will be acceptable to all Muslim scholars in accordance to the Fatwa #12086 dated 30/06/1409 and Fatwa no. 6619 dated 15/02/1404 (Appendix I and ii). These Fatwas clarify the Islamic religion concept relates to DNR decisions which will help:

- 1.1. To delineate the meaning and scope of DNR order.
- 1.2. To determine the patient's condition in which DNR order applicable.
- 1.3. To outline the process of DNR process.
- 1.4. To determine who decide and approve the DNR order.
- 1.5. To stipulate the differences between Basic Life Support. (Which cannot be denied at any time for patients) and Advance Life Support (ventilation support and invasive, pharmacological, defibrillation therapies).

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2.0 Definitions

2.1. Do Not Resuscitate (DNR):

No “CPR” means that all procedures for resuscitation are not initiated (i.e. in the event of cardiopulmonary arrest do not call CPR team or initiate chest compression. Defibrillation, cardio version, intubations or administer advanced cardiac life support medications). Other supportive measures to maintain the patient’s comfort and support that have been given before DNR was ordered may continue.

2.2. DNR (DO Not Resuscitate) Orders:


These are medical orders prohibiting specific cardiopulmonary interventions in the event of a cardiopulmonary arrest. These orders provide a mechanism for the clinician to guarantee the care will be consistent with a patient’s advance directive and other supportive measures i.e. basic care to maintain the patient’s comfort shall continue.

2.3. Decision to Sign a DNR Status:

The final insult of a cardiac arrest and its attempted reversal; even if successful would make all further care undesirable or ineffective. Therefore, the decisions to sign a DNR status to a patient must be based upon an outcome prediction. The following factors that should **not** enter in to DNR decision includes:

- o Gender
- o Age
- o Race
- o Economic
- o Social status

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- o Presence of infectious disease
- o Personal values of the resuscitation team

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Applicable reasons for DNR orders include the following:

- o No medical benefit.
- o Poor quality of life before resuscitations.
- o Anticipated poor quality of life after resuscitation
- o Patient preferences to forgo resuscitation.


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2.4. DNR Patients:

These patients are those suffering from progressive irreversible terminal illness, which are under constant view to be in the dying process. When in recovery, it is deemed, by current scientific evidence to be impossible. Only these patients should be considered for a DNR status. The following situations may be used as examples:

- o Advanced late stage cancer
- o Irreversible multi organ failure
- o Advanced chronic liver disease
- o Advanced congestive heart failure
- o Advanced pulmonary disease
- o Advanced dementia
- o Severe brain damage
- o Inoperable malformations that are incompatible with life
- o Irreversible or untreatable fatal neuromuscular disease
- o Diagnosed Brain Stem Death (the Saudi Centre for Organ Transplant (SCOT) guidelines (dated 18/06/1414) should be followed (Appendix IV

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- and V).
- o Untoward effects or drugs
 - o Severe multiple trauma.
 - o Conditions which have been associated with extremely low
 - o Chance of survival for example:
 - a. Inoperable congenital heart diseases
 - b. Werdnig Hoffman disease
 - c. Fatal Chromosomal anomalies
 - d. Fatal neuromuscular disease

2.5. **FOR (Failure of Resuscitation)**

Failure of resuscitation (FOR) is the patient who was admitted to intensive care and required full supportive measures but failed to respond to it.

2.6. **No Further Resuscitation (NFR)**

No Further resuscitation is an order made by the consultant in charge of ICU team for patient who has failed resuscitation.


2.7. **Active Management**

This includes inotropic support, renal dialysis haemofiltration, blood and blood products, TPN and ventilator support.

2.8. **Basic Care**

Patient, in whom aggressive treatment is meaningless, i.e. seems to delay death rather than prolong life. His/her basic care must include sedation & analgesia, IV

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fluids, maintenance of a free airway with room air, enteral feeding and personal hygiene.

2.9. Patients with Decision Making Capacity:

A patient who is:

- o An adult (16 years of age or older).
- o Conscious
- o Able to understand the nature and severity of illness involved.
- o Able to understand to possible consequences of, and alternative to, the proposed treatment
- o Able to make informed and deliberate choices concerning the course of treatment.

2.10. Patient lacking decision – making capacity


- o A minor (not an adult, e.g. Pediatric patient under the age of 16 years)
- o Unconscious unable to understand the nature and severity of illness involved
- o Unable to understand to possible consequences of, and alternative to, the proposed treatment.
- o Unable to make informed and deliberate choices concerning the course of treatment.
- o Has been declared legally incompetent by the court.

2.11. Legal Guardian

Any person legally authorized to act for a patient.

2.12. Cortical Brain Death

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Biological vegetative status is not included in this policy, i.e. Resuscitation (CPR) is mandatory if these cases are arrested at any time.

3. Policy

There is no specific tests that can be applies to identify patients who have no hop of survival, to aid in the decision to withhold/withdraw treatment.

- 3.1. This policy shall only apply to all patients registered in the ministry of health hospitals.
- 3.2. All inpatient. Home support services and those arriving in the A&E department should be fully resuscitated unless an approved order for Do Not Resuscitate and DNR form is completes and signed by the three (3) trustworthy specialized physicians (consultant in-charge and two consultant/ specialist.
- 3.3. This policy is intended for patients in the terminal phase of a devastating, scientifically irreversible. Life ending disease process. It is intended to accept that patient will die with peaceful dignity and not be subjected to an artificial and inappropriate suffering and prolongation of the drying process.
- 3.4. A DNR determination will avoid inappropriate resuscitation efforts being made when there is an abrupt clinical deterioration and also prevent an unnecessary transfer to any Critical Care Unit. Where there is a short exception for survival following resuscitative efforts for such patients or if prolonged would not be associated with any improvement in the quality of life.
- 3.5. Patient who on Failure of Resuscitation (FOR) No Further Result (NFR) order should be made by ICU consultant in charge.

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4. Procedure

4.1. The patient has been identified as being appropriate for DNR status, based up on the accepted definition (point – 2.4), the treating physician (Consultant in-charge) must document and sign in the progress notes his/her reasons for reaching this decision to describe.

4.1.1. The patient condition with emphasis on the natural history of the disease treated or untreated.

4.1.2. The quality of life if the patient undergoes CPR.

4.1.3. The unavailability of therapy that can improve the patient’s survival with improved quality of life.


4.1.4 Description of the patient’s decision making capacity.

4.2. The treating physician (Consultant in-charge) will then request another 2 referral trustworthy and specialized physicians. The two referral physician should be at the senior level of consultant or specialist from the same or another related sub-specialty to review the case carefully and document and sign their opinion in relation to the decision in the DNR status in the progress note of the patient medical record.

4.3. The treating physician (consultant in-charge) will write DNR in capital letters on the order sheet and then the patients file should be marked with a DNR sign that will be obvious to all health care providers working in the hospital.


4.4. Do Not Resuscitate from (DNR) (Appendix III) should be completed and signed by the consultant in-charge and then by two (2) involved physicians.

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- 4.5. No Further Resuscitation (NFR) order should be order by ICU consultant in-charge for patient when on Failure of Resuscitation (FOR).
- 4.6. There will be no endotracheal intubations or cardio-pulmonary resuscitation (CPR)
- 4.7. No active management should be commenced should be specified i.e. Inotropic support, renal dialysis/haemofiltration. Blood and blood products. (TPN) and ventilator support.
- 4.8. Other aspect of basics care will be continued to ensure the comfort and freedom from pain for the patient.
- 4.8.1. Every aspect of therapeutic regimen is determined by the criteria of overall welfare and comfort of the patient.
- 4.8.2. Certain procedures may cease to be justifiable and thus be contraindicated.
- 4.8.3. Therapeutics measures are not instituted, or are discontinued, unless discontinuation is expected to result in immediate demise.
- 4.8.4. It is important that the consultant in-charge specify for nursing and junior physicians what modalities of treatment will be excluded.
- 4.8.5. Any disagreement regarding the decision to DNR between treating physician (consultant in-charge) and referral physicians (consultant/specialist) will result in treatment being continued.
- 4.9. The relative should be told of the poor prognosis and their contribution to the discussion. If any should be considered and recorded.

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4.10. The relative should not be involved in the decision making process for the DNR including connection and disconnection of the ventilator us such) decisions do not fall within their areas of expertise (Fatwa Resolution no.12086 (Appendix I).

4.11. The documentation must clearly indicate that the decision has been explained to, understood by the patient and/or the most appropriate family member

4.12. Verbal/ Telephone orders from the treating physicians to nurses shall not be accepted or implemented.


4.13. If there is unresolved conflict between the patient or patients family and the treating physicians (consultant in-charge) it is the families right to ask for a second opinion or transfer the patient to another facility. However, the medical decision remains valid as per Religious Fatwa (Fatwa no.12086)

5. APPROACH TO THE PATIENT'S FAMILY

5.1. The treating physician (consultant in-charge) must discuss, in depth, how and why DNR decision was reached with either the patient who has decision – making capacity and/most appropriate/responsible family member if the patient is lacking decision – making capacity. He/she should clearly indicate, in simple language, all the reasons for reaching this decision and emphasize that further medical and/or surgical intervention would not alter the inevitable outcome.

5.2. The treating physician (consultant in-charge) should approach the discussion with honesty, sensitivity and compassion in order to minimize situations in

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which the patient and/or relative insists, in the face of all evidence to the contrary, that a full code be undertaken.

- 5.3. The treating physician (consultant in-charge) should make perfectly clear the points mentioned in sub-sections 4.5 to 4.7. Conveying these to the patients/family is essential, as many patients and/or their relatives' fear that by agreeing to a DNR status this may mean that the patient will be abandoned and left without basic care or treatment.


6. VALIDITY OF APPROVED DNR

- 6.1. The DNR status is only valid once the DNR form is signed and dated by ALL three (3) specialized physicians.
- 6.2. The approved DNR status is only valid for a single admission. The patient will be reevaluated according to his/her medical condition. At least once weekly for acutely ill patients and monthly intervals for long term stay patients through the same process. Patient must be re-evaluated for the determination of his/her code status during any subsequent admission(s).

7. OBTAINING DNR INFORMATION

Only the treating physician (consultant in-charge or senior registrar/fellow) will be the one to discuss the matters of DNR with the patient and the family. Other health team members i.e. junior medical staff, nurses, respiratory therapist and social workers etc., are highly encouraged to attend the meeting of discussion with patient and/or family members.

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8. PHYSICIANS RESPONSIBILITY

Physicians caring for these patients must recognized that dealing with DNR issues is part of their overall responsibility to both patients and their families. Personnel from Social Services and Religious Affairs Departments may be utilized to support patients and their family during this difficult and critical time.

9. SPECIAL CONDITIONS


9.1. Deterioration of Patient's Condition:

In those instances where conditions of the patient deteriorate before his/her DNR status has been determined. The patient is fully resuscitated. This may result in the patients being transferred to a Critical Unit. If so, the treating physician (consultant in charge) and the staff of the Critical Unit should then coordinate efforts which will lead to the determination of a DNR status on the patient which should be clearly documented in the chart. Upon discharge from the unit the patient should then not be readmitted back to the unit during this current admission. The DNR decision must be explained to the patient and/or his/her family.

9.2. Anesthesia During Surgery for DNR Patient

Patient with DNR orders undergoing surgical procedures will be provided appropriate anesthetic care and must receive proper medical interventions to counteract acutely reversible cardio-pulmonary arrest caused by anaesthesia agent and techniques. DNR orders will only be implemented when cardio pulmonary failure during surgery is believed or demonstrated to be caused by an underline disease processes (and not anaesthetic agents and techniques).

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9.3. DNR of Patient's Lacking Decision-making Capacity Who Do Not Have a Guardian:

- 9.3.1. When the attending physician (consultant level) determines that resuscitative efforts and contraindicated because they provide no benefit to the patient (e.g. Survive multiple trauma patient in A&E) the attending physician must discuss the rational of DNR with other two (2) referral trustworthy and specialized physicians.
- 9.3.2. The two-referral physician should be at the senior level of consultant or specialist from the same or another related sub-specialty to review the case carefully and document and signed their opinions in relation to the decision in the DNR status in the progress note of the patient medical records.
- 9.3.3. Do not Resuscitate form (DNR) (Appendix III) should be completed and signed b the attending physician (consultant level) and then by the two (2) involved specialized physicians.

9.4. Refusal of CPR by Patients or Legal Guardian

- 9.4.1. Patient or their legal guardians (if the patient is not competent) may refuse CPR, if this is medically sound and represent the best interest of the patient, as long as they are fully informed regarding the implications of their choice. CPR initiation against the patient

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wishes in these circumstances violates and individual's right to self determination and death with dignity.

9.4.2. Refusal of CPR from (Appendix IV) to be signed by patient/guardian witness and the treating physician in addition to the approved DNR form (Appendix III).

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10. TRAINING OF ALL PHYSICIANS

Hospital administration, Department Director and section Heads should, through appropriate meetings, and at regular intervals, stress to all their staff the necessity of considering the key principle of biomedical ethics including DNR status of their patients. It shall also be emphasized that this activity is part of their responsibilities as members of the medical care team.

11. DO NOT RESUSCITATE (DNR) FORM

- 11.1. This form should be legibly completed by the treating physician (consultant in- charge) to include patient's personal data and to clearly mention the diagnosis/date and the reasons for the recommendation DNR order the patient decision making capacity and the notification of patient's family/relative.
- 11.2. This form is included the name, signature date and the code number of the consultant in-charge in addition to the other two Consultant/Specialists involved in the decision making of the DNR.
- 11.3. The form should be kept as the first document in the patient medical record.

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11.4. This form is valid for single admission.

11.5. In case of re-admission by the treating physician and/or subsequent admission a new form should be completed and the old form should be marked as “VOID” and to be kept in the patient’s medical record.

11.6. To VOID – place a diagonal line across the whole form and write in large letters “VOID”. Patient and sign your name, code number and date form is voided.

11.7. Copy of the Fatwa No. 12086 on Arabic/English is printed at the back of the DNR form for information.

12. REFERENCES

12.1. Fatwa No. 12086, dated 30/06/1409

12.2. Fatwa No. 6619, dated 15/02/1404

12.3. DNAR Policy & Procedure prepared by AdHoc Committee under Saudi Heart Association.

12.4. MSD Guidelines – Intensive Care Unit, 2005

12.5. vumcpolicies.mc.vanderbilt.edu

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