

## **DNAR decisions in Pakistan, Middle East, and the UK: An Emergency Physician's Perspective**

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### **ABSTRACT**

Although resuscitation aims to preserve life and restore health, it is sometimes at the expense of increased suffering and disability to the receiving patient. In this situation, the treating physicians often end up in the dilemma of whether resuscitation is appropriate for the patient and have discussions with the patient and/or family. This may lead to a decision to "Do Not Attempt Resuscitation" (DNAR). In western societies, the patients have an option to opt out of Cardiopulmonary Resuscitation (CPR) if they are in the situation, and at times, the medical team can make a clinical decision when the efforts are deemed futile. This is supported in the legislation of those countries, and as an example, the UK law states. There is no obligation to give treatment that is futile or burdensome.<sup>(1)</sup> As the preservation of life in Muslim countries is of paramount importance due to religious reasons as well as cultures and traditions, a similar blanket approach to DNAR in Muslim countries is rarely seen. One of the earliest Fatwa (Islamic law) on this topic by Shaykh 'Abd al-'Azeez ibn 'Abd-Allaah ibn Baaz and Shaykh 'Abd al-Razzaaq 'Afeefi in the year 1986, states "if reviving the heart and lungs is of no benefit and not appropriate because of a certain situation, according to the opinion of three trustworthy specialist doctors, then there is no need to use resus-

citation equipment, and no attention should be paid to the opinions of the patient's next of kin concerning the use of resuscitation equipment or otherwise, because this is not their specialty."<sup>(2)</sup> This has led to physicians in Saudi Arabia being empowered to make DNAR decisions for their terminal patients and allow dignified death. The lack of similar legislation in Pakistan often places physicians in the unenviable situation of having to explain to patients and their families why CPR would be futile, and, in the absence of consensus, having to provide expensive, futile treatment, at the expense of the family, and other patients who may benefit from the resources used up. When possible, these discussions should be had by the treating specialty and the patient/families, but emergency physicians often find themselves in the awkward and undesirable situation of initiating these difficult conversations. The area to discuss and investigate here is about the ethical, religious, and legal implications of such a decision, and how an emergency physician can continue to act in the patient's best interest while keeping themselves safe.

### **KEYWORDS**

Resuscitation, Emergency, End of life care.

### **DEGREES OF RESUSCITATION**

The Pan Arab Resuscitation Council defines resuscitation as "the process of correcting physiological disorders (such as lack of breathing or heartbeat) in an acutely unwell patient."

Most doctors and patients associate resuscitation with CPR and use the two terms synonymously. Although CPR is a form of resuscitation, emergency physicians use resuscitation in a much broader context, expanding the term to include fluid resuscitation, intubation, and mechanical ventilation, CPR, extracorporeal membrane

oxygenation (ECMO), resuscitative hysterotomies (peri-mortem C-sections), and resuscitative thoracotomies, to name a few examples. It is important to understand that resuscitation does not only comprise of CPR as this is the basis of the medical and ethical considerations around DNAR decisions.

### **Basic Concepts of Do Not Attempt Resuscitation**

In the UK, and most of the western world, there is increasing use of advanced directives by patients regarding CPR and other

“heroic measures”. This ability to “opt-out” of resuscitative efforts is dependent on awareness and education of the patients making these advanced directives, and legally bind clinicians to avoid resuscitating such patients. This is different from the DNAR decisions made by clinicians for patients in whom they believe CPR to be futile.

## END-OF-LIFE DISCUSSION SITUATIONS

### Withdrawal of Treatment/Care

These are situations in which a treatment is already started but clinicians then discuss its futility. e.g. patient on a ventilator who is brain dead, a patient who has been started on inotropes, or as most emergency physicians will have encountered, a patient on whom someone has started CPR and are now planning to stop. These situations are usually extremely difficult for the family to understand and they are also emotionally charged and may not be able to reach consensus. These decisions are guided by medical knowledge that whenever the treatment/care is withdrawn, death will likely occur and therefore all we are doing is prolonging suffering. In these circumstances, there may be the one odd miracle where a patient recovers, but it is extremely rare, and the doctor or team of doctors make this decision as for medical experts.

### Ceiling of Care

This has arisen in recent times as situations where the outcome is still uncertain, but a high mortality rate is anticipated. In this situation, the discussion is different and tends to focus on how to manage the patient as per set protocols/guidance to ensure the best chance of survival. However due to comorbidities, frailty, and other factors (including cost in a private setting), the family and patient are informed that once a certain threshold has been reached, if there is no improvement (or deterioration), care will not be escalated further, as the treatment is either not likely to be tolerated, will prolong suffering at that point, or will already be futile by then. These are discussions emergency physicians sometimes must have but are best had by the treating specialty team (whether physicians, surgeons, pediatricians, or intensivists).

### Palliative Care

These are had with patients who have undergone all possible treatments and have now reached the stage where no new treatment or further treatment is expected to result in the condition improving. In these patients, the outcome is certain. The patients and families need doctors to have these discussions with them and explain the circumstances to ensure that the term palliation is not synonymous with getting no treatment, instead, it will be different treatment meant to preserve the quality of life and keep the patient comfortable, allowing a dignified death. Emergency physicians may find themselves having

these conversations, but these are best done by specialists in palliation or by the treating specialty depending on the circumstances.

## UK PRACTICE

The UK Resuscitation Council, Royal College of Nursing, and the British Medical Association (BMA) have produced guidance based on General Medical Council recommendations around DNAR decisions in the UK and state:

*“When a decision about CPR is discussed, made and recorded, clinicians should try to be clear about the basis for the decision. For example, it may be made with and/or for:*

- i- *a person who is at an advanced stage of dying from an irreversible condition, so CPR is contraindicated*
- ii- *a person who has an advanced illness and deteriorating health such that CPR will not work*
- iii- *a person for whom CPR is a treatment option with a poor or uncertain outcome.*
- iv- *a person for whom CPR is quite likely to restore them to a quality of life that they would value.*

*In the first two of these CPR will not be successful and should not be offered or attempted. This should be explained to the patient unless to do so would cause them harm. In the third and fourth, the wishes of the patient are paramount.”<sup>(3)</sup>*

It is standard practice for physicians to initiate a conversation and in case of a disagreement on the resuscitation status, document the conversation and why the patient will not be resuscitated. If the outcome is poor or uncertain, a second opinion is offered and if consensus can still not be reached, it may be taken to legal proceedings. In the case where resuscitation is likely to be successful, a patient may opt out of having CPR, but otherwise, every effort should be made to sustain.

These advanced directives are made before any life-threatening illness or injury occurs and empowers patients to have their say with regards to “heroic measures” and resuscitative efforts.

## SAUDI ARABIA PRACTICE

Currently, few hospitals in Saudi Arabia have a DNAR policy. There is however a fatwa regarding DNAR that was issued by the Presidency of the Administration of Islamic Research and Ifta, Riyadh, KSA, in their Fatwa No. 12086 issued on 28/3/1409 (1989).<sup>(4)</sup> This fatwa states:

“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”.

Due to various religious and ethical reasons, as well as patients not being as empowered or aware, the use of advanced directives is not commonly seen in Saudi Arabia or Pakistan. One argument is that the preservation of life is essential to the fundamentals of Islam, and therefore, an advanced directive refusing medical care or resuscitation would contradict the Islamic perspective. An advanced directive would require empowering the patient with not only the medical knowledge, but also the Islamic knowledge that is required to consider such decisions.

To this end, the fatwa further describes 6 circumstances where a DNAR would be allowed:

The following fatwa outlines the ‘do not need CPR’ hence a DNR order is allowed on patients;

- a. If the patient is dead on arrival at the hospital, there is no need to revive the patient.
- b. If the patient's condition is not fit for resuscitation according to the medical report of three trustworthy specialist doctors, there is also no need to resuscitate the patient.
- c. If the patient is suffering from a terminal sickness that is not responding to treatment and their end is certain, according to the testimony of three trustworthy specialist doctors, there is also no need to revive the patient.
- d. If the patient is incapacitated or in a state of mental inactivity due to a chronic illness, or suffering from an advanced stage of cancer, a chronic heart or lung illness, or the recurrence of heart and lungs failure, and it is the decision of three trustworthy specialist doctors, there is also no need to resuscitate the patient.
- e. If the patient shows evidence of untreatable brain damage, according to the medical report of three trustworthy specialist doctors, there is also no need to revive the patient.
- f. If resuscitation of the heart and lungs will be inefficient and inappropriate in a specific instance, according to the medical judgment of three trustworthy specialist doctors, there is also no need to revive the patient.

As this may indicate, there is limited role of advanced directive in Islam, primarily being for terminally ill

patients. In one hospital in Saudi Arabia, “three physicians including the attending, another consultant and a staff physician should sign the DNAR order electronically in the electronic health care system after discussion with the family or the patient, in which the system will flag the patient automatically as DNAR and the order will be valid for 6 months.”<sup>(5)</sup> In all other cases, the DNAR would “only be acceptable within the hospital during the patient’s admission.”<sup>(6)</sup>

However, it also clarifies that DNAR is a medical/clinical decision and the consent of the patient/family is not required.

### PAKISTAN PRACTICE

The lack of legislation around end-of-life care in Pakistan often places physicians in the awkward situation of having to explain to patient/families about the condition of the patient and the futility of any further treatment and being met with resistance on the issue of DNAR. With similar religious and ethical values as Saudi Arabia, the sanctity of human life is above all else, a belief consistent with the ideologies of Islam. Without the support from legal standpoint, physicians are unable to override patient/family requests regarding futile treatment and end up having to wait until the family is convinced to withdraw or withhold lifesaving treatment. Often, this is only possible when the funds required to maintain treatment run out, leaving the family in debt and financial crisis. The family often must deal with the anguish of abandoning their loved ones, that continues past their death, having felt burdened with the guilt of consenting to a DNAR order, as the physician cannot place it as a medical decision against the wishes of patient/family.

An article on palliative care in Pakistan notes:

“Many dying non-cancer patients are brought to hospital for curative treatments. Overtreatment at the end of life is commonly observed.”<sup>(7)</sup>

Not only does this place a huge financial burden on the population of which 45% live below poverty line, but pay for up to 90% of medical expenses, it also utilizes available resources, such as doctors, ventilators, ICU beds, etc. in the care of patients who have no realistic chance of survival, meaning the next patient who may benefit from them is denied life-saving treatment. In a country that ranks 186th out of 189 countries in the matter of total expenditure on health as a percentage of the gross domestic product (GDP) needs to be addressed urgently.

### DISCUSSION

This article aims to highlight how far Pakistan has to go compared to other countries, both Islamic and non-Islamic, when it comes to managing dying patients in emer-

gency departments, and how the law (or lack of) fails to empower both the healthcare professionals and their patients (and patients' families) to allow death in a dignified manner, avoiding further harm, suffering, financial burden, and burden on already scarce resources in situations where treatment is futile.

There is an urgent need for legislation that allows discussion with patients and their families, and helps in understanding what futile treatment means, and to allow clinicians to make decisions in their patients' best interests. When such legislation exists, it allows a course of action in cases where a difference of opinions is encountered between the treating team and the patient/family. For example, in the UK, when further treatment is deemed futile, the patient/family does not need to agree to a DNAR, and a second opinion need not be offered. However, when treatment may result in successful resuscitation, a second opinion is offered, and if a consensus still cannot be reached, the hospital legal department is then involved. In Saudi Arabia, if the DNAR decision is made by 3 competent, expert doctors, the patient/family does not need to agree to the decision, and a second opinion is not offered as three opinions are needed to make the decision. In cases where treatment may be successful, the clinicians are obliged by law to manage the patient and not withhold or withdraw any treatment.

This contrasts to Pakistan where if the patient/family do not want to withhold or withdraw treatment, clinicians are obliged to offer treatment until the patient/family consent to a DNAR. Cases taken to court have often sided with the patient/family in Pakistan, leading to clinicians feeling compelled to provide futile care to avoid being taken to court. No doctor in the UK has been punished for a DNAR decision made conscientiously in the patient's best interests, however a ruling in 2014<sup>(8)</sup> states that

"If a DNAR decision is made on clear clinical grounds that CPR would not be successful there should be a presumption in favor of informing the patient of the decision and explaining the reason for it."

The idea that these matters are too complex for legislation to account for and satisfy all religious, ethical, moral, and medical concerns should be disregarded as we have examples from other Muslim countries where such legislation exists.

## CONCLUSION

End of life and death is an aspect of care in Pakistan that is not talked about. Doctors being in the center of this situation, need to have a clear understanding regarding

these issues.

Clinicians need to feel safe when making these difficult decisions to allow a dignified death, free of pain, suffering, and remorse for patients and their families and making sure that resources are kept available for patients that may benefit from them.

It is high time, that the concerned medical, legal, religious, and governmental experts sit together to bring about legislation that helps deal with this taboo topic in a country where anticipated death is not talked about, decisions are made by families rather than individuals, refusing treatment is seen as being unislamic, and illness and death are viewed as the will of God.

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