

MEDICINE AND THE LAW

Emergency medical treatment and 'do not resuscitate' orders: When can they be used?

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The Constitution and the National Health Act provide that nobody shall be refused emergency medical treatment. 'Do not resuscitate' (DNR) orders require that certain patients should not be given cardiopulmonary resuscitation to save their lives. Whether there is a conflict between these two requirements is answered by considering: (i) the meaning of emergency medical treatment; (ii) the relationship between emergency medical treatment and DNR orders; (iii) the meaning of futile medical treatment; (iv) the relationship between DNR orders and euthanasia; and (v) when DNR orders may be lawfully used.

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The meaning of emergency medical treatment

The Constitution^[1] and the National Health Act^[2] provide that nobody shall be refused emergency medical treatment. The National Health Act does not define emergency medical treatment, but the Constitutional Court defines it as 'a dramatic, sudden situation or event which is of passing nature in terms of time'^[3] that can be cured through medical treatment. Emergency medical treatment therefore refers to acute episodes that can be rectified, rather than chronic incurable illnesses.

The need for emergency medical treatment arises when a person is faced with the real possibility of death, serious bodily injury or deterioration in health^[4] resulting from a sudden situation or event, but not as a result of a chronic illness. A patient at the end of a chronic illness, even though faced with the real possibility of death, would therefore not be entitled to emergency medical treatment as required by the Constitution.^[5] However, palliative care would still be allowed.

The relationship between emergency medical treatment and 'Do not resuscitate' orders

At face value, 'Do not resuscitate' (DNR) orders (the Health Professions Council of South Africa (HPCSA) refers to 'Do not attempt resuscitation' (DNAR) orders^[6]) appear to fly in the face of emergency medical treatment because they deny certain patients medical treatment in life-threatening situations. However, given the interpretation of 'emergency medical treatment' by the courts this is not so, because the legal meaning is confined to situations that are of a 'passing nature in terms of time' and not to underlying fatal conditions that are incurable (e.g. terminal chronic illnesses).^[3] DNR orders are only issued in situations where attempts to apply cardiopulmonary resuscitation (CPR) would be futile or against the wishes of the patient or persons legally able to consent on the patient's behalf.^[6] Such orders only apply to CPR and do not affect other treatments such as pain relief, medicines or nutrition.^[7]

The meaning of futile medical treatment

Although the concept of futile medical treatment is controversial, it generally means treatment that is useless, ineffective or does not offer a reasonable chance of survival.^[8] The World Medical Association (WMA) defines futile medical treatment as treatment that 'offers no reasonable hope of recovery or improvement' or from which 'the patient is permanently unable to experience any benefit'.^[9]

Determining futile treatment in the context of whether a person will survive or not is usually not difficult. Difficulties arise in the context of quality of life prognoses.^[8] In passive euthanasia situations, the South African courts have equated the artificial feeding of a patient in a persistent vegetative state (PVS) to medical treatment, and it may be discontinued if judged by society's legal convictions it 'did not serve the purpose of supporting human life as is commonly known'.^[10] The UK courts have allowed a DNR order to be issued, with the agreement of the parents, in respect of a 23-year-old patient who was not in a PVS but was born with severe malformation of the brain, had suffered from multiple disabilities since birth, lived in a nursing home, was regularly hospitalised, had no means of communicating with others, and appeared to experience acute pain. The court said that the test for the quality of life in such circumstances is whether life would be 'so afflicted as to be intolerable'.^[11]

The relationship between DNR orders and euthanasia

Euthanasia refers to conduct that 'brings about an easy and painless death for persons suffering from an incurable or painful disease' or condition.^[6] In South Africa active euthanasia is illegal,^[12] but passive euthanasia under certain conditions may be legal.^[10] Active euthanasia requires the doctor to intentionally contribute to the death of a patient, apart from the irreversible fatal underlying illness or condition that afflicts the person (e.g. by administering a lethal injection or medication).^[12] Passive euthanasia aims at preventing the prolonging of death by allowing an irreversible fatal underlying illness to kill the patient through withholding or withdrawing treatment. In passive euthanasia situations, palliative care must still

be given.^[7] Distinguishing between active and passive euthanasia may not appear to be logical, as in both the act or omission by the health professionals in denying medical treatment contributes to the patient's death, but the courts have taken a pragmatic approach in this regard.^[10]

DNR orders are a form of passive euthanasia, but only apply to the withholding or withdrawal of CPR. DNR directives do not affect palliative and other medical care for the patient,^[7] although the latter may be discontinued in passive euthanasia cases.^[10] In both DNR and passive euthanasia situations, the withholding or withdrawal of treatment allows the underlying fatal condition to cause the patient's death. DNR orders, as in passive euthanasia, aim to prevent prolonging the patient's death by letting nature take its course when treatment would be useless or ineffective.

When DNR orders may be lawfully used

DNR orders may be initiated: (i) where a patient has made an advance directive (e.g. a 'living will') or makes an informed decision to refuse CPR; (ii) when clinical judgement concludes that CPR is futile because it would not restart the patient's heart and breathing and restore circulation (e.g. where the patient is dying from some other irreversible condition); and (iii) when after discussions with the patient and/or his or her family an agreement is reached that the benefits of CPR are outweighed by the burdens and risks involved.^[13]

Where there is an advance directive (e.g. a living will) or an informed refusal of CPR

DNR orders differ from advance directives in that they are written by treating physicians. However, the doctor's decision may be based on the patient's wishes in an advance directive such as a living will or informed refusal by the patient or his or her representative.

Living wills as advance directives

A living will is an advance directive made while a patient is mentally competent. It states that if at any time a person suffers from an incurable disease or injury that cannot be successfully treated, life-sustaining treatment should be withheld or withdrawn and the patient left to die naturally.^[14] Depending on the wording of the living will and the condition of the patient, such a directive may be interpreted to include a request for a DNR order. Alternatively, the living will maker could add a clause requesting a DNR order if the person ceases to breathe or their heart stops beating and the prognosis is hopeless, and resuscitation is likely to result in severe suffering or a persistent, irreversible, unconscious condition with no meaningful existence.^[15]

Although living wills have not been recognised by statute in South Africa, at common law they should be respected by doctors provided they are satisfied that the conditions for the refusal in the living will have been satisfied and that the will represents the current wishes of the patient^[6] (e.g. it was made recently, and lodged with the patient's doctor or found on the patient's person).

According to the WMA Declaration of Venice on Terminal Illness, doctors 'should recognise the right of patients to develop written advance directives that describe their wishes regarding care in the event that they are unable to communicate and that designate a substitute decision-maker to make decisions that are not expressed in the advance directive'.^[16] The HPCSA implicitly recognises living wills in its *Guidelines for the Withholding and Withdrawal of Treatment*, which state that patients 'should be given the opportunity and be encouraged to indicate their wishes regarding further treatment and to place in writing their directives for future care in possible critical

circumstances', and that an 'appropriately drafted living will may be used for this purpose'.^[5]

The National Health Act furthermore allows for proxy decision-making on behalf of incompetent patients by allowing such patients to mandate a person in writing to make decisions on their behalf when they are no longer able to do so.^[2]

Informed refusals of treatment

Patients have the right, ethically and legally, to refuse treatment even if it is not in their best interests.^[17] An informed refusal, as in the case of an informed consent, occurs when patients who are mentally competent state that they wish to refuse treatment after they have: (i) had the implications, risks and obligations of such refusal explained to them; (ii) understood and appreciated the consequences of the refusal; and (iii) confirmed that they wish to persist with such refusal. Patients may revoke their consent at any time, and the treating doctor must then decide whether a DNR decision should be issued on the grounds of futility.

The National Health Act provides that health providers must inform patients of their right to refuse health services and explain the implications, risks and obligations of such refusal.^[2]

When CPR will be futile

When CPR will be futile, the physician in charge of the patient's care may order that the patient will not be resuscitated – even against the wishes of the patient or his or her representative, relatives or friends. There is no legal duty on doctors or health professionals to provide futile treatment to patients – even if requested by the patients, their representatives, relatives or persons close to them.^[18]

The HPCSA guidelines state that a DNR order should only be made after the doctor has: (i) consulted with the patient (if he or she is competent), the patient's representative (if there is one) or the patient's family or persons close to the patient – unless the patient has stated beforehand that he or she does not want their healthcare discussed with relatives or friends; and (ii) explained the situation to the other healthcare practitioners responsible for caring for the patient.^[5]

When CPR would be hopeless and the patient or the patient's representative, relatives or close friends request continued treatment, they must be given the option of transferring the patient to another institution where such treatment is available. If this option is refused and the health team considers treatment to be futile – provided this is confirmed by an independent healthcare practitioner – the treatment may be withheld or withdrawn.^[5] The patient and everyone else involved should, however, be told that all other forms of treatment and care will remain unaffected by the DNR order.^[5]

When the benefits of CPR are outweighed by the burdens and risks

If the benefits of CPR are likely to be outweighed by the burdens and risks associated with resuscitating the patient, it would not be ethically or legally justified to revive the person (e.g. where there is a high risk of substantial brain damage).^[19] If CPR will revive a patient who is terminally ill and suffering unbearable pain that cannot be alleviated through palliative care, or one in a persistent, irreversible, unconscious condition such that he or she can have no meaningful existence, these situations will outweigh any benefit of keeping the patient alive until he or she dies from the underlying condition. In such circumstances, it is likely that all those involved with caring for the patient and the patient's representative, family or friends would agree that the benefits of CPR are minimal, and a DNR order should be issued.

Recording of DNR orders

A proper record should always be kept of the reasons for issuing a DNR order, including whether it is based on the wishes of the patient or their representatives or on futility, and who was consulted. In addition to the HPCSA guidelines, practitioners should take into account guidance from their professional bodies and the relevant protocols in their healthcare settings.^[5] CPR decisions should also be reviewed regularly to ensure that they are appropriate,⁵ and this should be recorded.

1. Constitution of the Republic of South Africa Act 108 of 1996. Section 27(3).
2. National Health Act of South Africa No. 61 of 2003.
3. *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC) at 778.
4. Strauss SA. *Doctor, Patient and the Law*. 3rd ed. Pretoria: JL van Schaik, 1991.
5. Health Professions Council of South Africa. *Guidelines for the Withholding and Withdrawing of Treatment*. Pretoria: HPCSA, 2008.
6. McQuoid-Mason D, Dada M. *A-Z of Medical Law*. Cape Town, Juta & Co., 2011.
7. *Re J (a minor) (wardship: medical treatment)* [1990] 3 All ER 930.
8. Mason JK, Laurie GT. *Mason and McCall Smith's Law and Medical Ethics*. 8th ed. Oxford: Oxford University Press, 2011:476.
9. World Medical Association. *Handbook of Medical Ethics* 2005. <http://www.wma.net/e/ethicsunit/resources.htm> (accessed 2 January 2013).
10. *Clarke v Hurst* NO 1992 (4) SA 630 (D).
11. *Re R* [1996] 31 BMLR 127.
12. *S v Hartmann* 1975 (3) SA 532 (C).
13. British Medical Association, Resuscitation Council (UK) and Royal College of Nursing. *Decisions Relating to Cardiopulmonary Resuscitation*. London: BMA, Resuscitation Council (UK) RCN, 2002: paragraph 10.
14. Dhali A, McQuoid-Mason D. *Bioethics, Human Rights and Health Law: Principles and Practice*. Cape Town, Juta & Co., 2011:130.
15. South African Law Commission. *Draft Euthanasia Act*. Pretoria: SA Law Commission, 2004:54.
16. World Medical Association Declaration on Terminal Illness. Adopted by the 35th World Medical Assembly Venice, Italy, October 1983, and revised by the WMA General Assembly, Piñanesberg, South Africa, October 2006. Geneva: WMA, paragraph 8.
17. *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649.
18. *Airedale NHS Trust v Bland* [1993] 1 All ER 821.
19. Brazier M, Cave E. *Medicine, Patients and the Law*. 4th ed. London: Penguin Books, 2007.