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EDITORIAL

End-of-life care: 'do not resuscitate', 'Do not intubate' and 'Allow natural death'

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One of the critical choices that a patient or their legal guardian may have to make after knowing that comfort is now the goal of care is whether or not there should be any attempts to revive their patient if and when the vital organs stops.

DO NOT RESUSCITATE (DNR) ORDER

DNR order relates to circumstances where a patient has a cardiorespiratory arrest and no vigorous cardiopulmonary resuscitation (CPR), i.e., chest compressions, cardiac drugs, or placement of a breathing tube is given.

This DNR order is a well-documented and accepted concept in most of the developed countries. Here, nearly 15% of patients with DNR orders have undergone surgical procedures, including tracheostomy, gastrostomy and central venous catheter insertion.[1] In 1993, the **American Society of Anaesthesiologists** adopted guidelines for the anaesthesia care of patients with DNR orders, as well as other directives that limit the care. These were subsequently updated and emphasise the importance of the autonomy of the patient and shared decision making between patients and clinicians about the limitations of treatment in the operating room.[2] The **Limited Aggressive Therapy Order**, evolved in 2003, offers the patient the option of giving consent for cardiopulmonary resuscitation, particularly in situations in which a response has a higher rate of success, such as a witnessed cardiopulmonary arrest.[3]

DNR orders are usually established by competent patients or appropriate surrogates to provide a mechanism for withholding precise resuscitative therapies in the event of needs. It is important for health care institutions to develop policies to deal with DNR orders in the setting of anaesthesia and surgery.[4] The frequency of DNR orders is increasing as the people are better informed about the **Patient Self-Determination Act** and **Advanced Directives**.[5]

Several surveys on these issues have documented confusion on the part of individual practitioners and have demonstrated that only a small percentage of institutions have specific policies regarding perioperative DNR orders.[6-9]

DO NOT INTUBATE (DNI) ORDER

DNI order means that chest compressions and cardiac drugs may be given, but no breathing tube will be placed. While a patient request for a "Do Not Resuscitate order", doctor may ask whether or not he or she wants a "Do Not Intubate" wish. The two terms are separate because the patient may have trouble breathing before heartbeat or breathing stops. If the breathing problems continue, the heart or lungs may go into full arrest. Intubation, however, may avert cardiac or respiratory arrest.

Another concept is '**Allow Natural Death**' or **AND,** is a term used in some hospitals as an alternative to the more traditional DNR order. 'Allow Natural Death' order is used to make sure that only comfort measures, to provide excellent control of pain or other symptoms, are taken. This includes withholding or discontinuing resuscitation, artificial feedings, fluids, and other treatments that prolong the dying process without adding to patient's quality of life. Allowing a natural death means not interfering with the natural dying process. It also means that every effort will be made to have the patient's time of death be calm and peaceful.[10]

Even though DNR is considered as **passive euthanasia**, it is practiced in most parts of the world without much legal issues.[11] However, terminology like **assisted suicide** and **physician-assisted suicide** (PAS) are not synonyms of euthanasia.[12] PAS and active euthanasia are illegal in most parts of the world, with the exception of Switzerland and the Netherlands, there is pressure from some politicians and patient support groups to legalize this practice in and around Europe that could possibly affect many parts of the world.[13]

Professional integrity is to be maintained so as to avoid moral conflict. Distributive justice is served in that an open discussion of options, resources, and outcomes should follow with the patient and family. The **American College of Surgeons** has recently adopted similar guidelines.[14] These statements provide an important basis from which institution can develop policies to address the issue of perioperative DNR orders.

INDIAN PERSPECTIVE

The DNR order is still not documented legal practice in India. It is an oral communication between the clinician and the patient's relative or caregiver. The autonomy of the patient also remains a weak concept. Even the right to live a dignified

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life or die a dignified death has not been extensively discussed in judiciary. The law is ambiguous on most of the issues related to end-of-life care. The financial issues of the patient here appear to be the deciding factor. In most cases it is seen that health-care expenses are entirely borne either by the patient or by the patient's relative[15], but always plays an important role in continuation of the expensive procedures.

In India such guidelines are not followed in their entireness, or are difficult to follow when treating terminally ill patients. Even the Hon'ble Courts of India has debated for decades to admit passive euthanasia by means of withdrawal of life-support to patients in a permanent vegetative state (PVS) in the case of Aruna Shanbaug, who had been in a vegetative state for more than 37 years at King Edward Memorial Hospital, though Apex Court has finally admitted it on 7th March, 2011. As per Indian Medical Council (Professional conduct, etiquette and ethics) regulations, practicing voluntary euthanasia is also an unethical conduct.[16]

Guidelines were recently proposed for limiting life-prolonging interventions and providing palliative care towards the end of life in Indian intensive care units.[17] However, similar guidelines are lacking in an operating room set-up where the chance of survival in "witnessed arrests" is high.

Hon'ble Supreme Court of India on 9th march, 2018, has legalized the passive euthanasia in a landmark verdict, permitting 'living will' by patients on withdrawing medical support if they slip into irreversible coma.[16] This legalization on passive euthanasia in India has recognized that a terminally ill patient or a person in PVS can execute an "advance medical directive" or a "living will" to refuse medical treatment.

Many of us support the right of a terminally ill patient to die, but what if the right becomes an obligation? What is the potential for abuse by impatient heirs? Should dying patients have the right to order their doctors not to start or continue their medical treatment? Should the doctors be protected from prosecution if they shorten a patient's life-expectancy with pain-killing drugs? Many people would answer yes to both the questions. But, does this mean we need a 'right to die' law? There are more to the issue of euthanasia than first meets the eye.

The legal issues of PAS and euthanasia in India are covered in the **Indian Penal Code**. According to Penal Code 1860, active euthanasia is an offence under Section 302 (punishment for murder) or at least under Section 304 (punishment for culpable homicide not amounting to murder). The difference between euthanasia and physician assisted death lies in who administers the lethal dose; in euthanasia, this is done by a doctor or by a third person, whereas in physician-assisted death, this is done by the patient himself.

The issues related to DNR, DNI, AND, PAS and euthanasia are controversial which has recently caught the interest of media, public, politicians, and medical profession. Various socio-cultural organizations argue that hospitals do not pay attention to patients' wishes, especially when they are suffering from terminally ill, debilitating illnesses, and non-responding medical conditions. This is bound to change with the new laws, which might be implemented if PAS and active euthanasia are legalized.

On request, nothing can be done to assist the patient to end his life in India. It will be an offense by the patient of suicide covered under Section 309 IPC and the medical man who causes death of such person are abetting the act and is covered under Section 306 IPC (abetment of suicide).

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