THE IMPORTANCE OF DISCUSSING THE DO-NOT-RESUSCITATE (DNR) ORDER IN BRAZIL DURING THE COVID-19 PANDEMIC: REFLECTIONS PROPOSED BY A SATURATED HEALTH SYSTEM

A importância de discutir a ordem de não-ressuscitação no Brasil durante a pandemia de COVID-19: reflexões propostas por um sistema de saúde saturado

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Resumo

Introdução: A atual pandemia de COVID-19 trouxe aos serviços de saúde um risco de saturação. As tecnologias médicas da atualidade permitem o prolongamento artificial da vida após uma parada cardiorrespiratória por meio de variadas técnicas, tais como o uso de desfibrilador e drogas vasoativas, caracterizando o Suporte Avançado de Vida (SAV). Por outro lado, esses recursos podem proporcionar um prolongamento desnecessário e injustificável da vida, levando ao que conceituamos como distanásia. Objetivo: Este trabalho visa realizar uma revisão bibliográfica sobre a Ordem de não-ressuscitação (ONR), devido ao risco de saturação do sistema de saúde na vigência da pandemia de COVID-19. Método: Uma revisão bibliográfica incluiu artigos científicos publicados em inglês e português entre os anos de 2000 e 2020 nas bases de dados SciElo, PubMed e LILACS, utilizando os seguintes descritores: Infecções por Coronavirus; Ordens quanto à conduta (Ética médica); Bioética. Resoluções e informações contidas no site do Conselho Federal de Medicina e o Código de Ética Médica também foram utilizados. Resultados: A ONR ainda é um tema desconhecido e pouco discutido atualmente, visto que a terminalidade da vida envolve aspectos que não são simplesmente práticos, englobando, também, crenças, espiritualidade e outros fatores relacionados à experiência pessoal. Conclusão: A ONR precisa ser muito debatida e, principalmente, embasada por aspectos legais, o que ainda não acontece. Colocar a ONR como pauta recorrente de discussão visa proteger todos os envolvidos no processo de morte, minimizando os danos inerentes a esse fenômeno.
Palavras-chave: Infecções; Coronavírus; Conduta; Ética Médica; Bioética.

Abstract

Background: The current COVID-19 pandemic has brought health services a risk of collapse. The modern medical technologies allow artificial extension of life after a cardiorespiratory arrest through diversified techniques, such as the use of defibrillators and vasoactive drugs; these measures are called Advanced Life Support (ALS). On the other hand, these resources can provide unnecessary and unjustifiable extension of life, leading to what we conceptualize as dysthanasia. Aim: This work carries out a bibliographic review on the Do-Not-Resuscitate (DNR) order, due to the risk of saturation of the health system during the COVID-19 pandemic. Method: A literature review was carried out through an online search of scientific articles published in English and Portuguese between

2000 and 2020 in SciELO, PubMed and LILACS databases, using the following descriptors: Coronavirus infections; Resuscitation Order; Bioethics. Online documents and other information available in the Federal Council of Medicine website and the Code of Medical Ethics were also consulted. Results: The DNR order is still an unknown and little discussed topic, given that the end of life involves not simply practical aspects, also encompassing beliefs, spirituality and other factors related to personal experiences. Conclusion: DNR needs to be strongly discussed and, mainly, based on legal aspects, which does not yet happen. Putting DNR as a recurring topic of discussion aims to protect everyone involved in the death process, minimizing the damage inherent to this phenomenon.
Keywords: Infections; Coronaviruses; Conduct; Medical Ethics; Bioethics.

Introduction

The current pandemic of COVID-19, declared by WHO[1], brought to health services a risk of saturation, since the pathophysiology of the disease causes, in the most severe cases, a depletion of the respiratory system mainly by the so-called cytokine storm, with elevated C-reactive protein and ferritin. This seems to result in a situation of greater severity and mortality. Due to this severe condition, patients are often referred to the Intensive Care Units (ICU), where they receive ventilatory support through endotracheal intubation, and most severe conditions often evolve to cardiorespiratory arrest. Cardiorespiratory arrest (CRA) is a sudden event and is characterized by non-response to stimuli, absence of heartbeat, pulse and respiratory movements. If there is no immediate intervention, CRA leads to death[2].

Cardiopulmonary Resuscitation (CPR) comprises measures organized in a sequential response to cardiac arrest, including (1) Recognition of breathlessness and circulation; (2) basic life support, with chest compressions and rescue breathing; (3) advanced cardiac vital support, with definitive control of respiratory actions; and (4) post-resuscitation care. CPR is initiated without a medical prescription, but its interruption can only occur through a medical order; return of effective circulation and spontaneous ventilation; exhaustion or danger to the rescuer; injuries incompatible with life; transfer to a health unit that formally declares death; or the presentation of a Do-Not-Resuscitate (DNR) order[3,4].

According to an interview with the Federal Council of Medicine (FCM), Bishop Dom Raymundo Cardinal Damasceno Assis, says that Pope Pius XII, in 1957, in one of his speeches "Religious and moral problems linked to resuscitation" established three principles that remain very current: The first is that one has, in cases of serious illness, "the right and the duty to employ the necessary care to preserve life and health". The second principle is that, usually, this duty only requires the use of ordinary means, that is, "of means that do not impose any extraordinary burden on oneself, or on another". The third principle complements the second: "On the other hand, it is not forbidden to do more than what is necessary to preserve life and health, on the condition that the most serious duties are not lacking". This shows that DNR has been a moral and ethical concern since the beginning of CPR[5].

This discussion on DNR order and CPR should be highlighted now that the health system is at risk of saturation due to the large number of hospital admissions. The occupancy rate of ICU beds in the municipal and affiliated networks in São Paulo City is 67.1%. The total ICU beds occupancy rate in the state of São Paulo is 61.6%, with more than 11 thousand patients hospitalized for COVID-19[6]. So far, the state of São Paulo has had 1,361,731 cases of COVID-19 and 44,681 deaths[6].

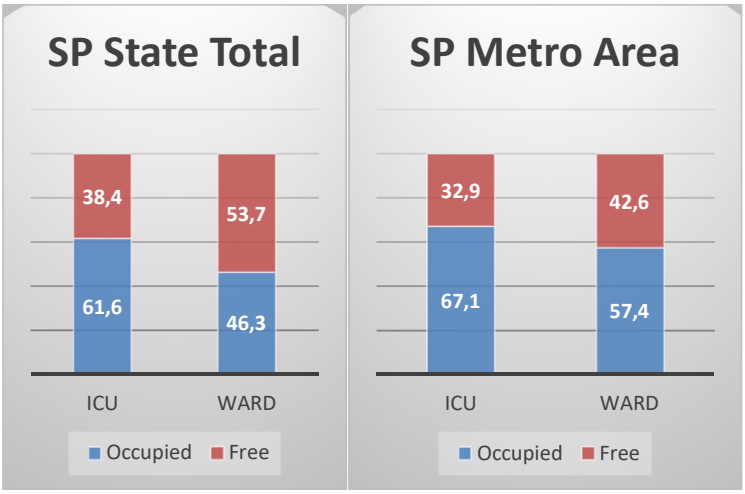

Figure 1. ICU beds occupancy rates in São Paulo city and São Paulo state. Available at: https://www.seade.gov.br/coronavirus/

The DNR order consists of the express manifestation of the refusal of cardiopulmonary resuscitation by a patient with advanced disease in progress and, in Brazil, it does not have a legislative backing yet, however, the Federal Council of Medicine has issued resolutions on the subject.

FCM Resolution 1.805/2006 resolves: "Article 1. The doctor is allowed to limit or suspend procedures and treatments that prolong the life of the terminally ill patient, who suffers from serious and incurable illness, respecting the will of the person or his legal representative.

1.1 The doctor has the obligation to inform the patient or his legal representative about the appropriate therapeutic modalities for each situation.

1.2 The decision referred to in the caput must be substantiated and documented in the medical record.

1.3 The patient or his legal representative is guaranteed the right to request a second medical opinion.

Article 2. The patient will continue to receive all the necessary care to relieve the symptoms that lead to suffering, ensuring comprehensive assistance, physical, psychological, social and spiritual comfort, including ensuring the right to hospital discharge"[7].

In 2007, the Federal Public Ministry filed a public civil action seeking recognition of the nullity of the above-mentioned resolution, adducing that "FCM does not have the regulatory power to establish as ethical a conduct that is typified as a crime; the right to life is unavailable, so it can only be restricted by law in a strict sense; Considering the Brazilian socioeconomic context, orthothanasia can be used improperly by family members of patients and by doctors in both public and private health systems". However, these arguments were not considered legitimate and were rejected by the Federal Justice[8,9].

FCM Resolution 1.995 / 2012 resolves: "Article 1. To establish early directives of will as the set of wishes, previously and expressly manifested by the patient, about care and treatments that they want, or not, to receive when they are unable to express their will, freely and autonomously.

Article 2. On the decisions about care and treatment of patients who are unable to communicate, or to express their will freely and independently, the doctor will take into consideration their prior directives of will.

2.1 If the patient has a designated representative for this purpose, his information will be taken into consideration by the doctor.

2.2 The doctor will no longer take into consideration the prior directives of the patient or representative who, in his analysis, are in disagreement with the precepts dictated by the Code of Medical Ethics.

2.3 The patient's prior directives will prevail over any other non-medical opinion, including the wishes of family members.

2.4 The doctor will document, in the medical record, the early directives of will that were directly communicated to him by the patient.

2.5 If the patient's early directives are not known, nor if there is a designated representative, available family members or lack of consensus between them, the doctor will appeal to the institution's Bioethics Committee or, in the absence of such Committee, to the Hospital's Ethics Board or the Regional and Federal Council of Medicine to base his decision on ethical conflicts, when such measures seem necessary and convenient.

Article 3. This resolution takes effect on the date of its publication"[10].

In addition to these resolutions, the Code of Medical Ethics determines in its Article 41: "It is forbidden for the doctor to shorten the patient's life even at the request of the patient or his legal representative.

Sole paragraph. In cases of incurable and terminal disease, the physician must offer all available palliative care without undertaking useless or obstinate diagnostic or therapeutic actions, always taking into consideration the patient's expressed will, or in their impossibility, that of their legal representative"[11].

According to Putzel et al., only 26% of doctors are aware of the absence of a standardization on DNR in Brazil. Most of the doctors interviewed (85%) would perform or prescribe a DNR order authorized by the patient or his representative[12]. Regarding to patients and family members, a study carried out in a hospital in Santa Catarina concluded that 82% of patients and family members did not know DNR and 60% of them would consider it an option[13].

In addition to all the regulations, the state of São Paulo defines that "the patient has the right to refuse treatments prescribed to him, as long as the therapeutic measures are duly clarified", according to law 10.241/99, Article 2, second paragraph[14].

Currently, medical technology allows life to be prolonged through artificial methods, such as defibrillators, endotracheal intubation and vasoactive drugs. The set of these measures is called Advanced Life Support (ALS)[15]. The ALS is increasingly gaining space in hospitals, which is very important to ensure the maintenance of life and the recovery of potentially severe patients, who, without these resources, would certainly not survive[16].

On the other hand, these resources can lead to an unnecessary extension of life through unjustifiable methods, leading to what we conceptualize as dysthanasia. According to Sanchez & Seidl, dysthanasia is the attempt to fight death at any cost[17], promoting unnecessary suffering and agony, which denies the principle of nonmaleficence. Thus, it becomes an opposite conduct to the concept of orthothanasia, which, according to the same authors, is defined as "the non-investment of obstinate, and even futile, actions that aim to postpone the death of an individual whose illness insists

on moving forward, leading to the progressive failure of vital functions". Orthotanasia is, then, a conduct related to palliative care, which aims to provide greater quality of life to individuals whose disease has no possibility of cure[18,19,20].

Method

A literature review was carried out through an online search of scientific articles published in English and Portuguese between 2000 and 2020 in SciELO, PubMed and LILACS databases, using the following descriptors: Coronavirus infections; Resuscitation Order; Bioethics. Online documents and other information available in the Federal Council of Medicine website and the Code of Medical Ethics were also consulted.

Results and Discussion

The DNR order is still an unknown and little discussed topic, given that the end of life involves not simply practical aspects, also encompassing beliefs, spirituality and other factors related to personal experiences. This topic becomes even more urgent and important in times like the COVID-19 pandemic. However, it is necessary that this discussion be taken to the most diverse places with the support of all available means, which we have seen happen in a rudimentary way. The emblematic case of journalist Ana Michelle Soares, who was diagnosed with metastatic cancer at 35, shows that she began to face death in a very unexpected way, not allowing the treatment of the disease to lead to further illness through therapy side effects and placing her quality of life as a top priority. Thereby, we can demonstrate that our life span, in a broader perspective, is not what really matters, but how well we can make use of the time that we have left.

DNR ordering, even though it is a practice that always aims at well-being and quality of life, can be poorly indicated, which leads us to conclude that constant training of doctors and awareness of the general population, especially those who have highly degenerative diseases and, consequently, have a greater chance of needing a DNR order. When needed, it is fundamental that DNR orders are to be well documented and well indicated, leading to an improvement in the use of this resource in medical practice.

The absence of a formal regulation can be explained by the fact that death has a unique character, restricted to particular understandings, varying from individual to individual. In spite of this, a regulation that protects doctors and users legally and guides of actions for health professionals is a key piece for DNR ordering not to become an obscure practice. Therefore, it is of paramount importance to create conditions for this measure to be applied safely and efficiently, aiming at orthothanasia.

Although DNR prescriptions are of a medical nature, it should be discussed by a multidisciplinary team, since a post-resuscitation therapeutic plan or palliative care maintenance depends on everyone (i.e., nurses, physiotherapists, nutritionists, psychologists, and more).

We see that, in addition to the importance of a Brazilian legislation for the subject, it is necessary to engage society more in this area, and this is only possible through campaigns in the most diverse media, especially social media, which nowadays can reach a major part of the population. The people are of fundamental importance in order to these laws to be implemented, contemplating all of societal demands and making DNR ordering more than a choice, but a right decision, based on bioethical principles.

Conclusion

Death has always been a taboo present in society and, even today, with the alarming numbers of COVID-19, the discussion about this theme is constantly avoided or endowed with censorship. However, death should be dealt with naturally, especially among health professionals, who often deal with the end of life. The decisions made by the healthcare team at this time have a major future impact, as they will determine the direction of life: dysthanasia, orthothanasia or its termination. In that scope, DNR needs to be strongly discussed and, mainly, based on legal aspects, which does not yet happen. Putting DNR as a recurring topic of discussion aims to protect everyone involved in the death process, minimizing the damage inherent to this phenomenon.

References

1. Cucinotta D, Vanelli M. WHO Declares COVID-19 a Pandemic. Acta Bio Med. v. 91, n. 1, p. 157-60, 2020.
2. Silva, AB; Almeida, OS. Suporte avançado de vida e as novas diretrizes da american heart association 2010: um levantamento bibliográfico. Revista de Saúde e Comunidade, v. 1, n. 9, p.62-71, set. 2013.
3. Oselka, G; Troster, EJ. Aspectos éticos da ressuscitação cardiopulmonar. Revista da Associação Médica Brasileira, v. 47, n. 1, p.17-18, 2001.
4. Zanini, J et al. Parada e Reanimação Cardiorrespiratória: Conhecimentos da Equipe de Enfermagem em Unidade de Terapia Intensiva. Revista Brasileira de Terapia Intensiva, São Paulo, v. 18, n. 2, p.143-147, 2006
5. CFM. Entrevista ao CFM: CNBB apoia ortotanásia. 2012. Disponível em: <http://portal.cfm.org.br/index.php?option=com_content&view=article&id=23257%3Aentrevista-ao-cfm-cnbb-apoia-ortotanasia&catid=3%3Aportal&Itemid=1>. Acesso em: 28 abr. 2019.
6. Boletim Completo do Novo Coronavirus. Governo de São Paulo. 2020. Disponível em: https://www.seade.gov.br/coronavirus/. Acesso em: 17/12/2020.
7. Conselho Federal de Medicina. Resolução nº 1805, de 28 de novembro de 2006. Na fase terminal de enfermidades graves e incuráveis é permitido ao médico limitar ou suspender procedimentos e tratamentos que prolonguem a vida do doente, garantindo-lhe os cuidados necessários para aliviar os sintomas que levam ao sofrimento, na perspectiva de uma assistência integral, respeitada a vontade do paciente ou de seu representante legal. D.O.U. Brasília, DF, Seção 1, p. 169
8. Brasil. Seção Judiciária do Distrito Federal. Sentença nº 2007.34.00.014809-3. Ministério Público Federal. Conselho Federal de Medicina. Relator: Roberto Luis Luchi Demo. Brasília, DF, 1 de dezembro de 2010. Diário Oficial da União. Brasília
9. CFM. Justiça valida Resolução 1805, que trata sobre ortotanásia. 2010. Disponível em: <https://portal.cfm.org.br/index.php?option=com_content&view=article&id=21154:justica-valida-resolucao-1805-que-trata-sobre-ortotanasia&catid=3>. Acesso em: 28 abr. 2019.
10. Conselho Federal de Medicina. Resolução nº 1995, de 31 de agosto de 2012. Dispõe sobre as diretivas antecipadas de vontade dos pacientes. Diário Oficial da União. Brasília, DF: Imprensa Oficial da União, 31 ago. 2012. Seção 1, p. 269-270
11. Código de Ética Médica: Resolução CFM nº 1.931, de 17 de setembro de 2009 (versão de bolso). Publicação do Conselho Federal de Medicina
12. Putzel, EL; Hilleshein, KD; Bonamigo, EL. Ordem de não reanimar pacientes em fase terminal sob a perspectiva de médicos. Revista Bioética, v. 24, n. 3, p.596-602, 2016.

13. Eidt, V; Bruneri, GD; Bonamigo, EL. Ordem de não reanimar sob a perspectiva de pacientes oncológicos e seus familiares. O Mundo da Saúde, v. 1, n. 4, p. 385-403, 2017.
14. Assembleia Legislativa de São Paulo (Estado). Lei nº 10241, de 17 de março de 1999. Dispõe sobre os direitos dos usuários dos serviços e das ações de saúde no estado e dá outras providências. São Paulo, SP: Imprensa Oficial, 18 mar. 1999. Seção 1, p. 1.
15. Mazutti, SRG; Nascimento, AF; Fumis, RRL. Limitation to Advanced Life Support in patients admitted to intensive care unit with integrated palliative care. Revista Brasileira de Terapia Intensiva, p.294-300, 2016. GN1 Genesis Network. http://dx.doi.org/10.5935/0103-507x.20160042.
16. Jaul, E; Zabari, Y; Brodsky, J. Spiritual background and its association with the medical decision of DNR at terminal life stages. Archives Of Gerontology And Geriatrics, v. 58, n. 1, p. 25-29, 2014.
17. Sanchez y Sanches KM, Seidl EMF. Ortotanásia: uma decisão frente à terminalidade. Interface (Botucatu). 2013;17(44):23-34.
18. Torres, RVSD; Batista, KT. A ordem de não ressuscitar no Brasil, considerações éticas. Comunicação em Ciências de Saúde, v. 4, n. 19, p.343-351, 2008.
19. Menezes,RA e Ventura, M. Ortotanásia, sofrimento e dignidade: entre valores morais, medicina e direito. Rev. bras. Ci. Soc. 2013, v. 28, n. 81, p. 213-229.
20. Felix, ZC et al. Eutanásia, distanásia e ortotanásia: revisão integrativa da literatura. Ciência & Saúde Coletiva, v. 18, n. 9, p.2733-2746, 2013