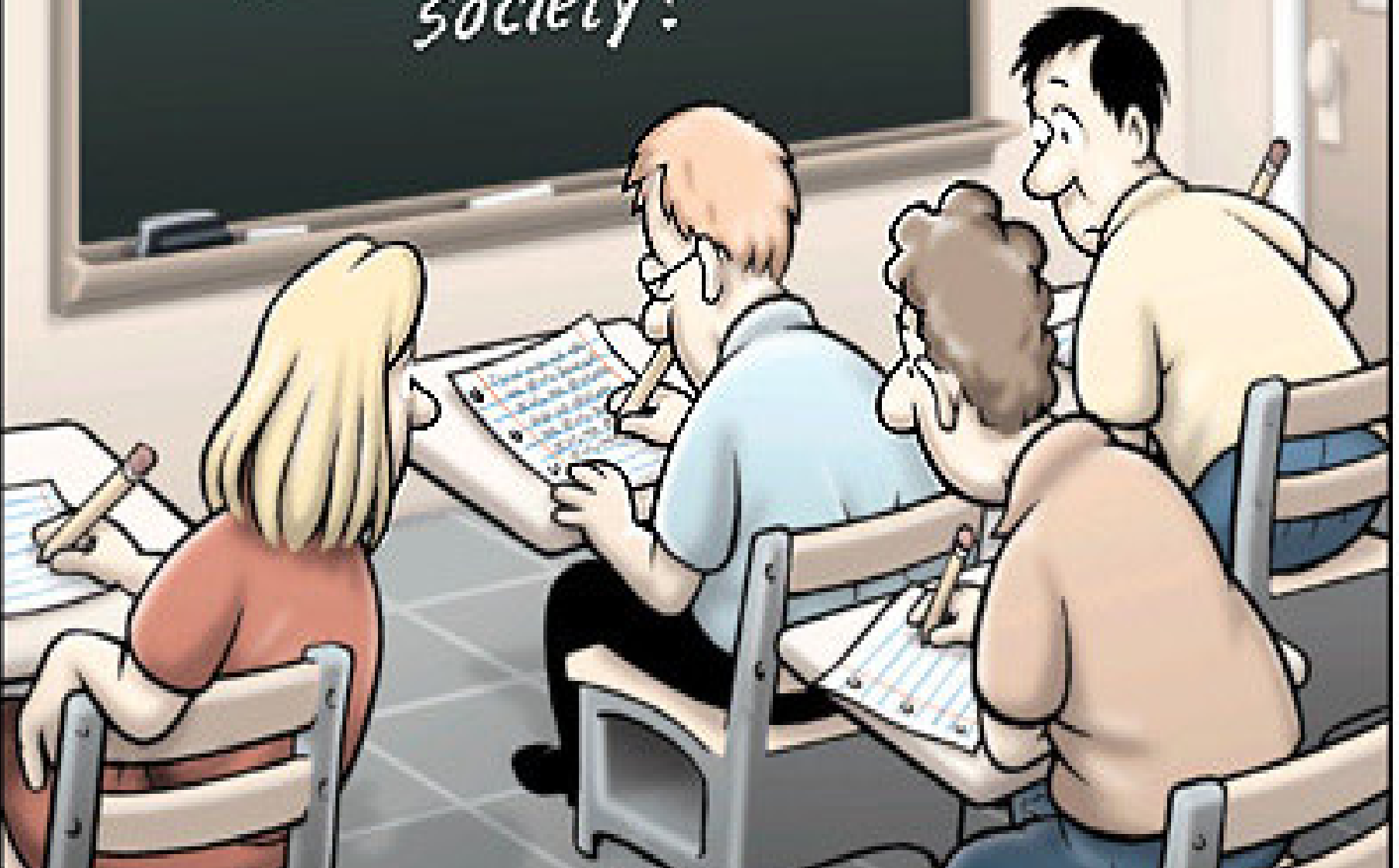


ETHICS IN OUR REGION

Said Abuhasna, MD. FACP. FCCM. FCCP
Chairman, Dept. Critical Care medicine
Chairman, Ethics Committee
Associate Professor in Medicine, FMHS
JHMI/Tawam Hospital
30/12/2008 - Dubai



How important are ethics in today's society?



CASE.....ONE

74 Y O male deaf bed ridden for 2 years, has HTN, DM and CVA fed by family members. Aspirated and Admitted to the hospital for treatment. He was given appropriate medications but deteriorated became hypotensive with severe dyspnea. As you are his doctor and you arrived to his room, his son tells you that “ I do not know what to do DOC!”.

1. Start CPR, Intubate and send to ICU
2. Explain to the son that you will do comfort measures while reasoning so.
3. Call the legal affairs and ask for advice if you do nothing.
4. Ask him to SIGN A CONSENT for comfort care

Before we ask this question

who decides?

First.....Think

We Are in the **East NOT WEST**

Different Culture

Different Religion

Who Participates in End-of-Life Decision Making?

Most often in Western healthcare, the physician is the major decision maker in the end-of-life process. In an integrated review of current research, Baggs and Schmitt found that physicians often make these decisions alone or with minimal input from others.

End-of-life issues:

End-of-life issues are religiously, emotionally, and politically charged topics. As Islam teaches, everyone will face death, and the way we and those we love die is of great individual importance

Processes of healthcare providers

Processes of family members

Laying the groundwork²⁸

Develop a trusting relationship with the patient's family^{27, 28}



Provide information about illness or injury^{27, 28}



"Plant seeds" about prognosis²⁸



Understand the critical illness²⁷

Recognize futility or probable bleak outcome²⁸



Shifting the picture²⁸

Provide consistent perspective on the patient's prognosis²⁸



Hold meetings with the family²⁸



Involve other disciplines (eg, chaplaincy, social work)²⁸



Come to terms with what this illness or injury means for the patient:
Suffering²⁸
Values^{26, 27}
Quality of life²⁷
Life story²⁷



Accepting a new picture²⁸

Continue supportive relationship with the family



Reiterate information as needed²⁸



Redirect hope from cure to comfort²⁸



Take on the role of surrogate decision maker^{26, 27}



"Face the question"²⁸ to forgo life-sustaining therapies

The Qur'an

offers a sober reminder that there are times when human beings need to recognize their own limits and entrust nature to take its own course (Qur'an 39:42).

- The **Prophet** (SAW) said while addressing the person whose funeral rites he was reading.

“How fortunate you are that you died while you were not afflicted with illness”,

At several IJC meetings held in Mecca, Jeddah, and Amman, Muslim jurists of different schools ruled that once invasive treatment has been intensified to save the life of a patient, **life-saving equipment cannot be turned off unless the physicians are certain about the inevitability of death.**

- However, pain-relief treatment or withholding or withdrawing of life-support treatment, in which there is an intention of allowing a person to die when there is no doubt that their disease is causing untreatable suffering, are permissible as long as the structures of consultation between all the parties concerned about the well being of the patient are in place

Ethics Committee

Administrative Decision No. 17/2006

Ethics Committee and Consultation Service – Permanent

Dr. Said Abuhasna	Critical Care Medicine	Chairman
Dr. Saad Aswad	Ob/Gyn	Vice-Chair
Dr. Fares Chedid	Pediatric	Member
Prof. Frank Branicki	Surgery FMHS	Member
Dr. Yasser Salam	Medicine Department	Member
Dr. Sheikha Al Ameri	Neima Clinic	Member
Dr. Moh'd Hidayatullah	Palliative Care	Member
Dr. Sherief Islam	Pathology	Member
Dr. Sharif Qandil	Pharmacy	Member
Dr. Nasreen Khawaja	Psychiatry	Member
Dr. Mukhtar Abdel Wahab	Dental Centre	Member
Mr. Ahmad Al Niyadi	Legal Affairs	Member
Mr. Alec Napier	Customer Services	Member
Mr. Steve Matarelli	Nursing Services	Member
Mr. Osama Ibrahim Hassan	Clergy	Member

Ethics Committee

Goals:

- To promote the rights of patients
- To aid shared decisions making between patients and clinicians
- To foster fair polices and procedures
- To encourage good patient-centered outcomes
- To bolster the ethical tones of health care professionals and the institutions in which they care for patients.

Consultation and case review

- Begins with a request for consultation
- Evaluation.
- Decision

D o N o t R e s u s c i t a t e
P o l i c y (D . N . R .)

?

COMFORT CARE POLICY

DNR

The wording.....Gives a negative
Feeling. ...Neglect

COMFORT

Gives a softpositive to family

Abstract

- **Do Not Resuscitate orders and ethical decisions in a neonatal intensive care unit in a Muslim community**

D E da Costa, H Ghazal and Saleh Al Khusaiby Department of Child Health,
Royal Hospital, Ministry of Health,
Sultanate of Oman

Conclusion

- Religious and cultural issues often play a more vital role in decision making by parents and physicians than economic considerations, especially in Arab nations. Physicians are often reluctant to even Approach the subject of DNR with parents, believing it will not be accepted, may cause a loss of trust in the physician, or "it is unfair to ask parents to be involved in the decision making process involving life and death". This has led to a significant increase in the number of handicapped survivors, and to a shortage of intensive care beds, as a result of inappropriate intensive care being given for an inordinately long time.

Conclusions

- **Relationship and communication** — between patients and their families, between patients and patients' families and the healthcare team, and between members of the healthcare team—are the key elements that will enhance the end-of-life decision making. Improving this process will decrease the distress experienced by both healthcare providers and patients' family members, honor our patients, and make the ICU a more humane and caring place in which to die

Care of Terminally Ill Patients: An Opinion Survey among Health Care Providers in the Middle East

M Rahman¹; F Abu-Zidan²; Y Ibrahim^{1,2}; S Abuhasna¹

¹Tawam Hospital in Affiliation with Johns Hopkins, Critical Care Department, Al-Ain, UAE

²United Arab Emirates, Surgery Department, Al-Ain, UAE

PURPOSE AND HYPOTHESIS

- The purpose of the study was to compare the opinion of health care provider on the care of terminally ill patient
- We hypothesize training background and level of responsibility effects the management decision regarding terminally ill patient.

- **Does religion play a role in making patient no code?**
 - Yes No
- **Which of the patients below would you consider for no code?**
 - A patient with very little hope of survival for more than a week
 - A patient who may live for several years but whose quality of life is very poor according to your opinion
 - A patient who may survive for several year but whose quality of life is very poor according to the patient's definition
 - All of the above patients should be admitted
- **What does no code mean to you?**
 - Patient should have no investigations and made comfortable
 - Patient should be treated maximally short of CPR and intubation
 - There is no such thing as no code. Every patient regardless of his disease should be treated maximally
 - This is euthanasia (deliberately killing patient).
- **Patients in ICU with no real chance of recovery do you agree with any of the following?**
 - *Do not escalate therapy* (Maintaining mechanical ventilation, dialysis, presser therapy etc)
 - *Withdraw* meaning complete or partial removal of aggressive therapy (Discontinue mechanical ventilation, dialysis, and pressers)
 - Deliberately administer therapies to *accelerate the patients death* (euthanasia)..
 - *Continue* maximal therapy *including CPR*.
 - *Continue* Maximal therapy *short of CPR*.

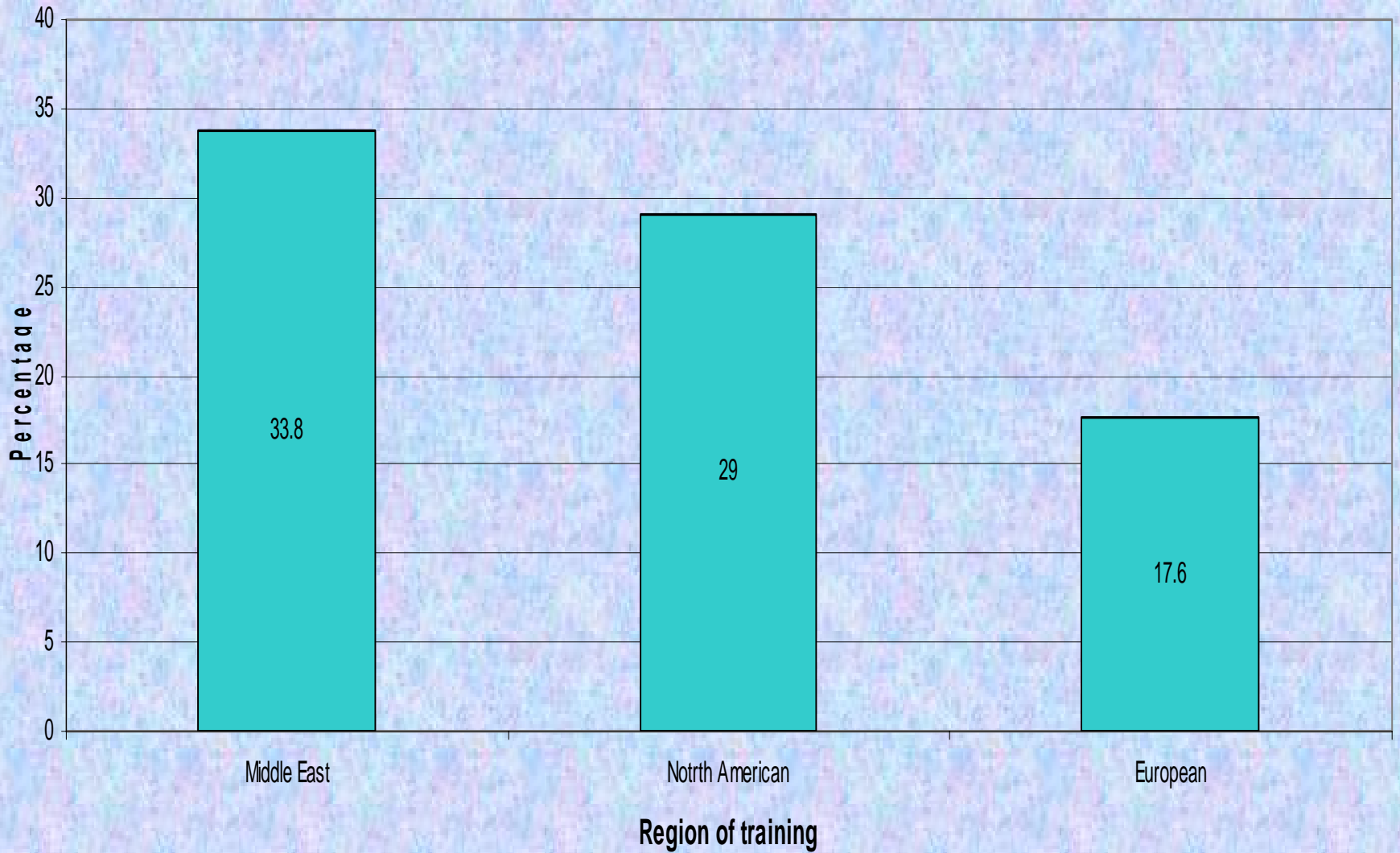
COUNTRIES

- **United Arab Emirates**
- **Saudi Arabia**
- **Kuwait**
- **Oman**
- **Egypt**
- **Jordan**
- **Sudan**
- **Syria**
- **Iraq**
- **Iran**
- **Lebanon**

RESULTS

- DNR was equivalent to comfort care: 39%
- Do not escalate therapy versus withdrawal in futile cases: 55%.
- Admitted DNR patient to ICU was acceptable for 47.7%
- Continue feeding the DNR patient:94%
- Chances of DNR patient to be medically neglected: 46%
- Best time to discuss DNR prior to patient getting severely ill: 60.5%

Training Background of Responders



CONCLUSIONS

Despite different training back ground majority of the members of Pan Arab Critical Care Society have a general agreement on care of terminally ill patient. **Majority of the hospitals, where respondent worked, did not have a formal DNR policy.** Religious concerns play a major role during dying process. There is concern among physicians about level of care provided to patient once labeled DNR . **Withholding therapy seems to be the most acceptable way of managing futile patient.** Holding feed is almost universally rejected. Further studies are needed to form a consensus and formulate a DNR policy considering the local religious and social concerns.

CONSENT



1) If your loved one is dying, would you sign a consent to hold treatment which is considered by the physician to be of no meaningful benefit.

Yes

No

2) Do you feel comfortable to sign consent to withhold artificial measure of resuscitation in case your relative is terminally ill?

Yes

No

3) Would you feel guilty if you are signing the consent to hold artificial means for your dying relative?

Yes

No

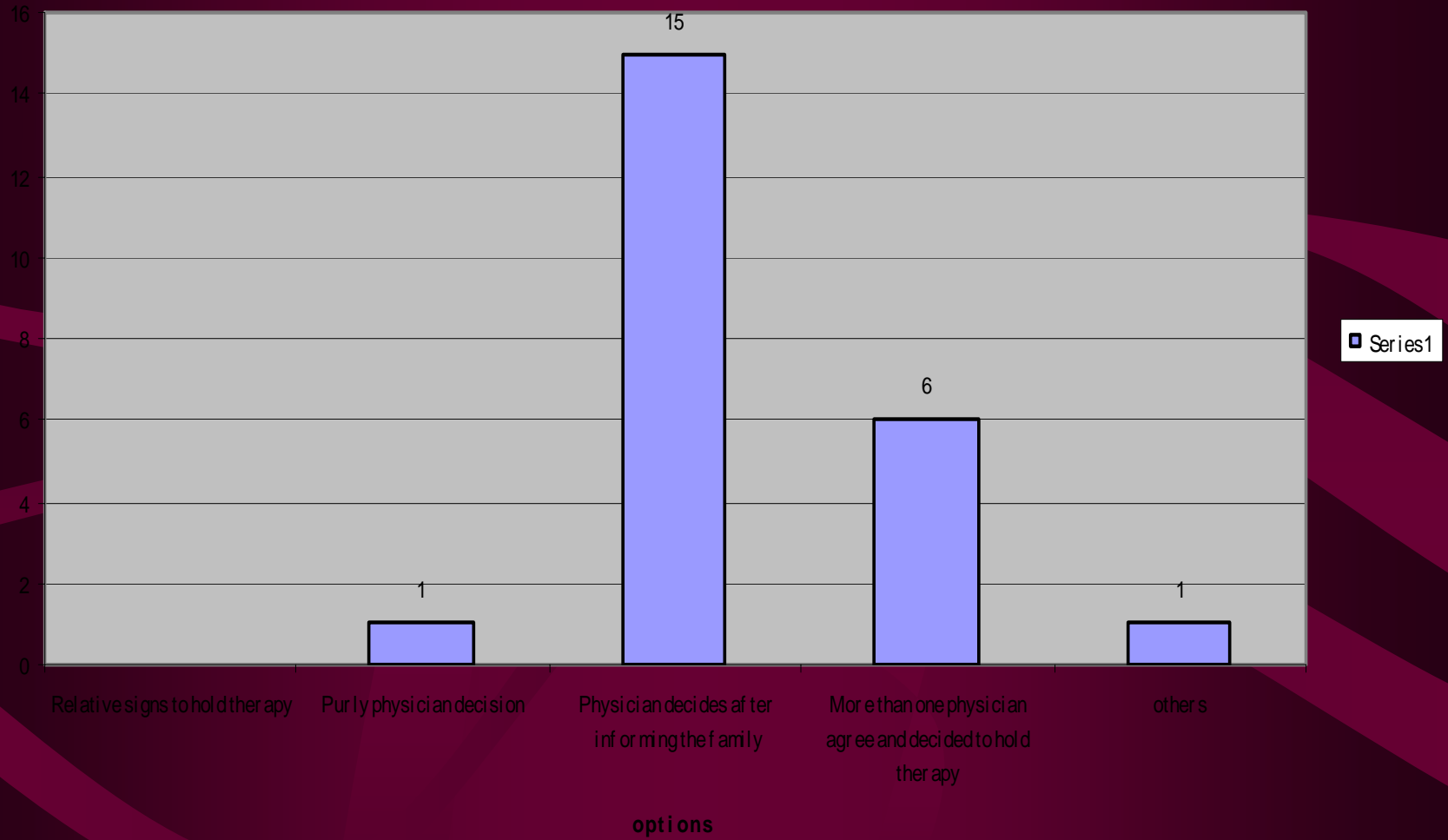
4) Do you think it is necessary for the close relative of the dying patient
a) to signing a consent to hold therapy?

b) that the decision should be made purely by physician?

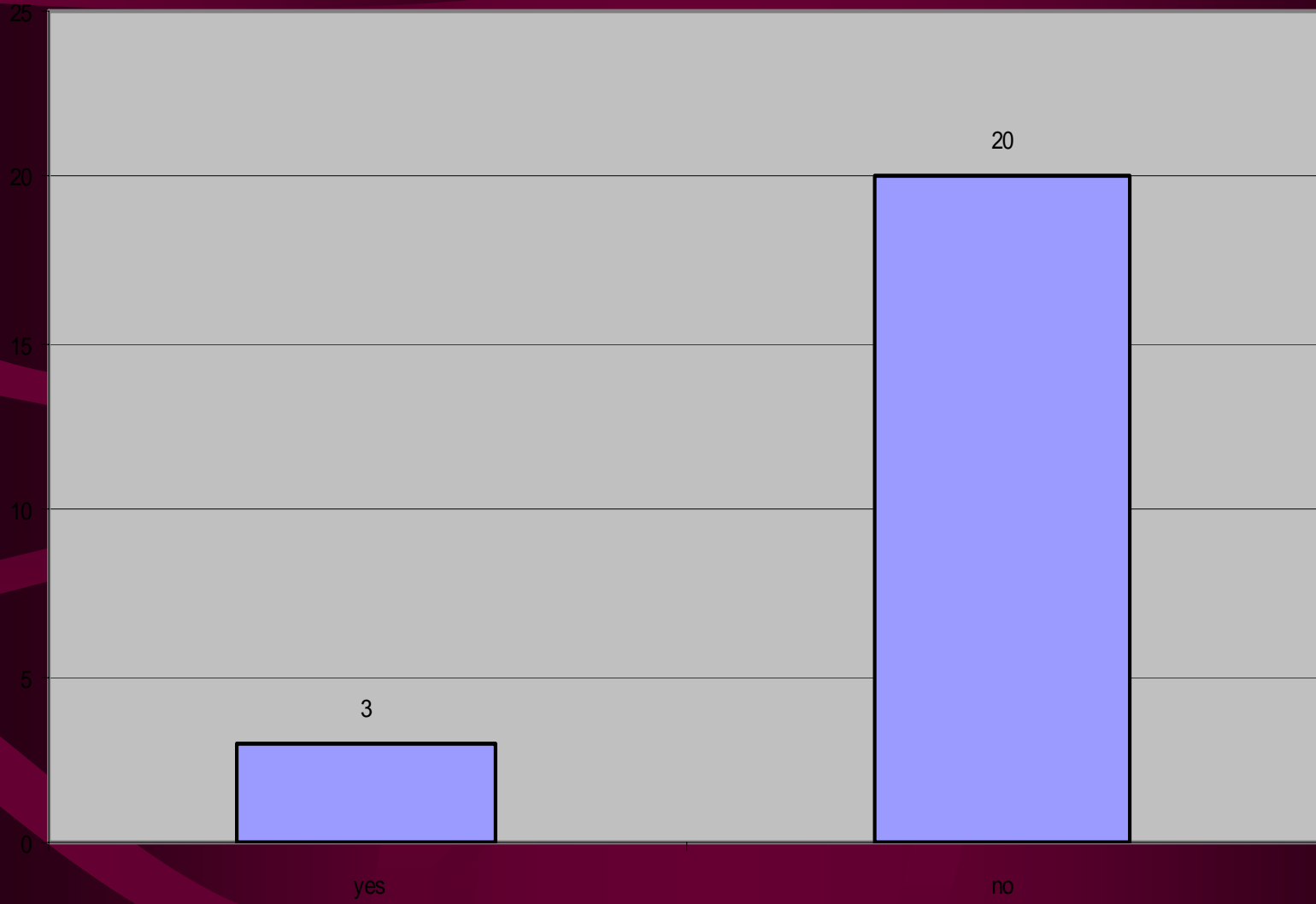
c) that physician should decide after informing the family?

d) that more than one physician should decide to withhold futile therapy?

best approach to withhold therapy

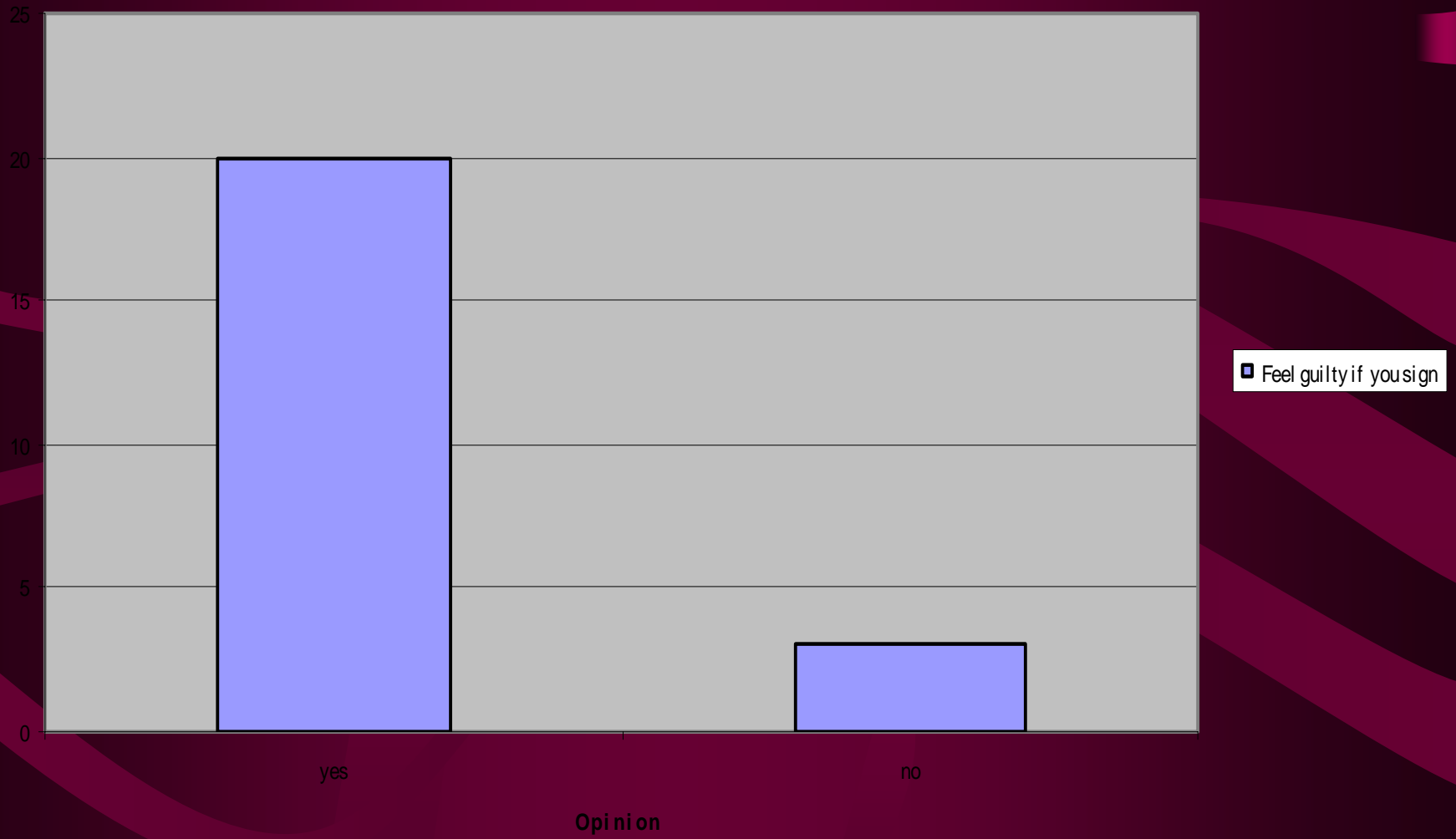


Sign consent to hold therapy



■ Sign consent to h

Feel guilty if you sign



The development of written institutional policy is an important step towards the establishment of a formal and reasonable process for reaching negotiated and informed decisions and eliminating surreptitious practices

The purpose of establishing a DNR—Policy **comfort care policy** is to ensure that a decision is made through a medically responsible, ethical, and sensitive process that protects the rights of patients and families and that there is adequate communication between those involved in the patient care.

Such policy

- Invaluable to staff covering end of life situations
- Spares the patient from futile interventions.

CONCLUSION:

As a medical expert, the physician is responsible for obtaining and evaluating the clinical and laboratory information needed to reach a balanced judgment on resuscitation.

1. An assessment of probable prognosis
2. Quality of life
3. Mental competency

Conclusion: AS A Physician

- Ensure that the active medical care of the patient continues at an appropriate level, and that prognosis is continually re-evaluated.
- Should Not ask family to SIGN Written Consent
- The responsibility of decision can not be delegated to other health care professionals
- Must sit with the patient or family and talk about comfort care.
- Must inform family by explaining to withdraw aggressive interventions

Conclusions.....

- Decisions to forgo life-sustaining treatment are among the most challenging that patients, their surrogates, and clinicians face

Finally.....

**WE MUST NOT LOSE SIGHT
OF THE GOALS OF
MEDICINE: PRESERVING
FUNCTIONAL LIFE, AND
COMFORTING **IF** WE CANNOT
CURE**

What Strategies Facilitate End-of-Life Decision Making?

- **Change in Perspective**
- **Awareness of Meaning for Patient's Family Members**
- **Interdisciplinary Approach**
- **Relationship and Communication**

• Palestine



Don't Mess With

My

Right of Return

