Ethical Aspects of Resuscitation in Nursing

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Abstract
In order of responsible approaching to all the challenges of modern nursing, the nurse accepts responsibility and commitment in providing health care within the legal domain of nursing practice. Nursing is facing a complex request for identification and elimination of the patient's problems involving ethical approach, knowledge, skills and abilities. In their work, nurses daily encounter with resuscitation of patients, where they are required by conscience and commitment to save every human life. Cardiac arrest is a condition characterized by extremely high mortality. Especially important topic relates to nurses employed in the field of primary health care, who work in isolated clinics in rural areas, where they are often the only health workers and must themselves make a decision on the initiation and implementation of cardiopulmonary resuscitation. In the context of consideration of ethical principles of resuscitation there are generally accepted fundamental principles in all cultures around the world relating to: well-being, harmlessness, justness and autonomy. Discussion and research into ethical issues concerning cardiopulmonary resuscitation should be continued; it is necessary to focus, confront, and answer these questions through continued efforts to improve the practice of nursing.

Keywords
Ethics; Resuscitation; Nursing

Introduction
In order of responsible approaching to all the challenges of modern nursing, the nurse accepts responsibility and commitment in providing health care within the legal domain of nursing practice. Nursing is facing a complex request for identification and elimination of the patient's problems involving ethical approach, knowledge, skills and abilities. In their work, nurses daily encounter with resuscitation of patients, where they are required by conscience and commitment to save every human life. Cardiac arrest is a condition characterized by extremely high mortality. Especially important topic relates to nurses employed in the field of primary health care, who work in isolated clinics in rural areas, where they are often the only health workers and must themselves make a decision on the initiation and implementation of cardiopulmonary resuscitation.

Through long history, cardiopulmonary resuscitation passed through different phases that were associated with technological and scientific development.

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of the time. We find first credible clues about resuscitation in the Bible, the Old Testament, which describes one child cardiopulmonary resuscitation very realistically. Medieval scientists Paracelsus and Vesalius describe first attempts at resuscitation of patients in the fifteenth and sixteenth centuries. They successfully applied the methods of ventilation of patients by blowing air into their mouth using the blacksmith bellows. The first defibrillation was recorded in the eighteenth century in England, which was performed by a member of a volunteer society. Development of technics and mechanics introduced first precursors of today's respirators in the nineteenth century [1]. The era of modern cardiopulmonary resuscitation has begun in the mid-twentieth century, when Dr. Peter Safar introduced a combination of artificial ventilation and cardiac massage as well as standards for performing resuscitation. The successful outcome of resuscitation has provided for many people a long lasting and productive life. The rate of survival and complete physiological recovery after resuscitation is low. In some cases, resuscitation deepens the suffering and dying or even leaves the patient in a state of permanent vegetation. Prolonging life at all costs is not always an acceptable goal of medicine. The decision on starting resuscitation raises in patients and relatives sensitive and potentially disturbing questions. These decisions are influenced by individual and international and local cultural, legal, traditional, religious, social and economic factors. It is therefore important that health workers understand the principles and issues before getting into the situation to make decision on resuscitation [2, 3].

Basic goals of cardiopulmonary resuscitation in nursing are:

- to save life,
- to reduce suffering,
- to restrict disability
- to return patients from clinical death (specific goal).

Basic Ethical Issues

Ethics (Ethos Greek-custom, ETHIK) is part of philosophy that studies and evaluates the moral value, origin and principles of morality. Ethics, in the other sense indicates morality and purity of, particularly, some profession, as for example, ethics of health professionals - medical ethics, journalism ethics, research ethics, etc. [4]. Medical ethics represents, in fact, a set of principles or rules of conduct by which medical personnel must be guided when making decisions about what is right and what is wrong, what is allowed and what is forbidden, what is good and what is bad for the patient, but also for the community. The adoption of these decisions is often not easy [5].

- Is it ethical to begin the process of cardiopulmonary resuscitation or to give it up
- Is it and when it is ethical to suspend the procedure of cardiopulmonary resuscitation

Cardiopulmonary resuscitation should begin with each person experiencing cardiac arrest if for the procedure there are no specific contraindications. Failure to take resuscitation measures is an oversight subjected to ethical and judicial discretion. If it is proven that the patient could survive, it can be followed by a suit for a criminal offense. This attitude obliges health institutions to provide all the necessary equipment to perform cardiopulmonary resuscitation. It is very important to emphasize the basic ethical principles and the principles associated with the procedure and effects of resuscitation as a key modern medical segment. In the context of consideration of ethical principles of resuscitation there are generally accepted fundamental principles in all cultures around the world relating to: well-being, harmlessness, justness and autonomy.

Ethical Principles in Resuscitation

One of the most important obligations is to inform appropriately the patient about his/her condition and get permission for the proposed methods of treatment which might include the resuscitation procedure. Many patients do not want to talk about death and the procedures that are implemented in the case of clinical death. Therefore, this is a subject of frequent discussion of employees in the health industry:

- whether to talk at the beginning of treatment about the possibility of cardiac arrest
- it actually means death
- hear the patient's attitude what to do in such situations.
• Well-being means that health workers in assessing the benefits and risks must strive to benefit prevailing in the final outcome. This usually means starting resuscitation, or, sometimes it means withholding resuscitation. Every decision on cardiopulmonary resuscitation must be adapted to individual circumstances of the patient. We have to assume that not every decision is suitable for all patients in certain circumstances. Decisions should not be based on assumptions concerning, for example, the patient's age, disablement or professional subjective view of the patient's quality of life.

• Harmlessness means not to cause harm. Resuscitation should not be initiated when it is obvious that it is impossible and when it is against the wishes of the conscious and self-possessed patient. Therefore, this means that if the doctor estimates that an attempt of resuscitation would be certainly futile and even harmful to the patient or the patient verbally or in writing form, expressed his/her desire not to be resuscitated, then this principle has priority.

• Justness means obligation to provide equally quality assistance within society. If there is a possibility of resuscitation, it should be available to all who might benefit from it.

• Autonomy refers to providing an opportunity for the patient to independently decide based on relevant information, instead of to health workers decide on it for them. This principle is especially prominent over the last 30 years, and it is based on laws such as the Helsinki Declaration of Human Rights. Autonomy requires that the patient is properly informed, able to decide without pressure from the environment, and consistent with the wishes.

Advance orders apply to any aspect of the patient's wishes. Rejection does not need to be in writing form to be valid. Patients should be sure that health professionals and relatives are aware of their wishes if they should be implemented. Witnesses of outpatient cardiac arrest usually do not know the patient's situation and wishes, thus advance order often is not available immediately. In such circumstances, resuscitation is performed immediately, and questions are asked later. In some countries such as the UK, advance orders are binding. When resuscitation is indicated, but there are no clear advance orders it is assumed that health workers do their best for successful resuscitation [6].

When Not to Start Resuscitation?

Health workers can not be required to treat patients if it is contrary to clinical judgment. The decision is often complex and should be left to older and more experienced members of the healthcare team. Decision not to start resuscitation leads to raising many ethical and moral questions such as: What is denied? Who should decide and who should be to consulted? Who should be informed?

• What is denied - not starting resuscitation means that in the event of cardiac or respiratory arrest, cardiopulmonary resuscitation is not performed. While earlier in many countries demands for not to start resuscitation were written by doctors, without consultation with the patient, family and healthcare professionals, today in many countries there are clear procedural requirements or guidelines that tell when resuscitation can be denied.

• Who should decide and who should be consulted - people have legal and moral rights to be involved in making decisions about them and the question of not starting resuscitation should be discussed with the patient. Although family members have no legal right to decide, it is desirable to include them in the decision.

• Who should be informed - once decision is made it must be clearly communicated to the patient and the patient's relatives. Orders, reasons and signature of persons involved in the decision-making process must be recorded in the medical records [7].

When to Stop Resuscitation?

Most resuscitations are unsuccessful and must be stopped. Factors influencing the decision include: anamnesis, expected outcome, time elapsed from cardiac arrest to initiation of resuscitation, time to defibrillation of the heart, and duration of advanced life support in a patient with asystole and no reversible causes. In many cases of outpatient cardiac arrest, resuscitation is performed until gathering additional information. As soon as it becomes clear that resuscitation is impossible, then it is stopped if, despite the implementation of measures of advanced life support, the patient remains in asystole. However, if during resuscitation, even during extended one, spontaneous circulation occurs, it seems reasonable to continue for longer than the specified time. Also in case of arrest due to drug overdose or in drowning, prolonged resuscitation procedures may be effective. The hardest
and most responsible is to decide on the termination of resuscitation.

Resuscitation performed reasonably and compassionately should be directed not only to establishment of respiratory and circulatory functions, but also to recovery of mental function. This means that resuscitation is often successful in cardiopulmonary terms but not always cerebrally, which results in damage to the central nervous system of various degrees, to the most severe degree of permanent loss of consciousness - persistent vegetative state. Thus, the development of resuscitation amended the definition of death by a new concept – “social death”. It should be noted that the goal of resuscitation is not prolonging the agony when there is no hope for healing, healing means newly dignified life and not the degradation to vegetative state. Therefore, cardiopulmonary resuscitation is not performed in individuals who are in terminal stage of the heavy and incurable diseases [8].

**Ethical Issues in Resuscitation Research Work**

Some authors believe that doctors and nurses have no obligations, neither families have the right to require resuscitation treatment that has no obvious benefits [9-11]. The European Commission has ruled that patients have the right to self-determination, including the right to refuse help treatment or therapy. The most common barriers in patients are:

- Only 32% of patients discuss health care at end of their life with healthcare professionals
- 75% of patients prefer to concentrate to stay alive than to talk about death
- 64% of patients are not assured by healthcare professionals that they will take care of them when they get very sick
- 37% of patients do not know what kind of health care they want when they get very sick.

The most common barriers in doctors and nurses are:

- 70% of healthcare professionals consider there is very little time to discuss and talk about everything that the patient needs to know otherwise
- 21% of healthcare professionals think that the patient is not sick enough

- The patient does not know what he/she wants
- Priorities of the patient change over time.

Responsibility of the healthcare professionals comes down to assessment whether the patient has adequate capacity of awareness for decision-making, informs the patient about the diagnosis, risks, prediction, benefits, and consequences of the entire range of available medical interventions. The components of so-called “good death” mean a clear decision-making, based on the participation of the patient and family members in making decisions about treatment and preparation for dying – to know what to expect. Decision-making by the patient requires an increased level of knowledge, ability of patients to obtain realistic perception of the benefit or harm of interventions, reducing conflict in decision-making, reducing the number of patients who remain undecided or passive in relation to choices, and improving the alignment between the value systems of patients and the option that is chosen. Healthcare professionals must always keep in mind that:

- patients should not be abandoned before death
- patients should not suffer before death
- patient’s autonomy is always in the center
- the most important is communication.

**Informed Consent**

Informed consent for the first time appeared after World War II, followed by development of legal prerogatives, and after the Nuremberg trials, therefore an essential consent of human subjects is necessary for research and treatment. There are three principles - autonomy, well-being and justice, and there are four essential elements of informed consent:

- Competence
- Understanding
- Voluntary
• Consent.

Autonomous authorization by individuals relating to a medical intervention is a competent act, which is received through notification, voluntary aspect, and consent to the intervention. Severity of the patient's disease often makes the patient unable to make decisions regarding their own medical care, so it requires determining surrogate who further gives consent. In general, the capacity of medical decision-making is an ability to give informed consent to a particular medical intervention or to make an informed refusal of the intervention. It follows that capacity is not a legal term, but that competence is. Patient-person may have the capacity to make the decision to accept an intervention, but without having capacity for other types of decisions.

In the case where the patient after hearing the doctor recommendation refuses further treatment, there is an ethical problem. In such a case the principle of well-being is the duty of the doctor to help the patient, but the principle of autonomy is the duty to respect the patient's wishes, and this leads to a mutual conflict.

Discussing do not Resuscitate Decision

• healthcare professionals have an ethical responsibility to initiate conversations

• if the patients are terminally ill, or have incurable disease with an assessment of survival rate up to 50% for less than three years

• if patients are in acute, life-threatening condition

• patients who require such considerations

• Conversation is conducted with the patient or representative, if the patient is incompetent.

These decisions of patients may have physiological, emotional, financial, legal, scientific, educational or religious influence on others. When the patient is so ill or injured that clinical judgment suggests that the objectives of restoration of health and functions are unattainable, and therefore certain medical interventions are not indicated, and should be restricted, we talk about moribund patients or “terminally ill” patients, where there is the so-called “physiological futility”. In this case, it may be appropriate for the doctor to recommend the suspension of life support [12]. The majority of clinicians do not inform patients about the near death. Personal wishes of patients are very important. Medical futility - medically ineffective or useless treatment, “futile likelihood”. Who decides if the intervention is futile, how to solve disagreements between doctors and patients or their representatives in this case - healthcare professionals should not make these decisions alone. Only 30% of citizens of the United States make the following directives [13].

• “WITHHOLDING”- REFUSAL OF STARTING TREATMENT

• DNR - DO NOT RESUSCITATE

• DNI - DO NOT INTUBATE

• “WITHDRAWING”- FULL DISCONTINUATION OF STARTED TREATMENT.

• 82% of family doctors in Ontario favor the use of advance directives

• 62% of clinic patients want to discuss issues related to the treatment of life-support

• Only 12.5% of Canadians are opting for advance directive

• 23% of patients do not want starting treatment, 34% do want neither resuscitation nor intubation, and 11% of patients want treatment discontinuation.

• In Europe, an advance directive is relatively rare, and only 29.5% of patients received to these intensive units discuss and signs “medical will” before admission to the hospital

• Do not resuscitate orders are taken into consideration when the patient is in a terminal condition and when it seems that death is imminent. Less than 2% of the patients with not resuscitate order survived until hospital discharge (medical goal of silent death).

A permanent authorization of representative for medical care, a legal form - document that defines the trustee, surrogate or proxy is a form in which the patient
appoints the trustee - surrogate to whom the patient gives the right to make medical decisions instead of him/her when he/she becomes incompetent. Legal acts called “instructions to healthcare professionals” (in some countries there are laws on so-called natural death) are actually legal documents. The official “living will” is a document in which the patient determines whether he/she wants or not to receive specific medical treatment at the end of life - how they want people to behave towards them; these are not legal acts, but a kind of instruction.

“Values history-inventory” is a document in which the patient indicates their values and gives an opinion about life, specifying what the person considers valuable in life and it can help the family or healthcare professional if they need to make decisions about end of life on the patient’s behalf. The healthcare professional should “tailor” advance directive for a particular health situation, not generally, but specifically for the disease (such as COPD) and it should relates to the decisions on intubation or cardiopulmonary resuscitation (CPR).

**Resuscitation is not Performed**

- the patient has a valid do not resuscitate order

- If there is sufficient evidence that the patient is dead

- If one cannot expect physiological improvement because all vital functions failed despite maximum therapy applied - a moribund patient.

**Reasonable Resuscitation Measures**

- Transferable do not resuscitate order relates to the patient’s not to reanimate wish which should be respected by emergency and home care doctors (bracelets, necklaces or special marks)

- Too many people suffer unnecessarily at the end of life because of these mistakes.

- The legal, organizational and economic barriers prevent excellent care at end of life.

In America in the hospitals financed by the country, doctors are required to ask patients if they have the instructions; these are required or proposed for signing. However, doctors slowly react to the wishes of terminally ill patients relating less aggressive care at the end of life. This care, at least in intensive units is managed mainly by traditional practice to prolong life, instead of the patient’s wishes, which are often difficult to discern due to the general condition of the patients. In any research work, the well-being of respondents should not be compromised by research, and any covert research should be avoided.

**Conclusion**

Modern resuscitation through its innovative techniques and the availability of medical instruments of resuscitation (automatic and external defibrillators, auto pulse, quicker arrival to the patient) training of non-medical staff, development of new technologies, techniques and availability of information on the topic led to significant expanding the boundaries in survival after cardiac arrest. However, it also led to dilemma not only in determining the time of death, but also when to stop reanimation procedures. According to the ethical principles besides care about prolonging the life it is important to pay attention to the aspect of quality of life after successful resuscitation. In many cases, however, it happens that the ethical principle of a fundamental right which is human life prevails when taking into consideration the current life-saving and possible consequences.

It is important to respect the principles of charity, justness, harmless, autonomy, and respect for life. Often some of these principles may contradict but priority is given to the one which is more actual in a given law of the country, hospital and the like. The most prevalent is the principle of respect for human life.

Discussions and research into ethical issues concerning cardiopulmonary resuscitation in nursing should be continued; it is necessary to focus, confront and answer these questions through continued efforts to improve the practice of nursing.

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