PRE-HOSPITAL CARE AND DO NOT ATTEMPT TO RESUSCITATE ORDERS: THE LEGAL AND ETHICAL CONSEQUENCES

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PRE-HOSPITAL CARE AND DO NOT ATTEMPT TO RESUSCITATE ORDERS: THE LEGAL AND ETHICAL CONSEQUENCES

by

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ABSTRACT

The purpose of this dissertation is to provide clarity on the legal position of Do Not Attempt to Resuscitate (DNAR) orders for both patients and health care practitioners, especially emergency health care practitioners in the pre-hospital environment of South Africa.

As there is no legislation governing DNAR orders in South Africa, emergency health care practitioners face uncertainty as to the medical treatment to be provided to a patient who has a DNAR order and is in cardiac arrest. Furthermore, emergency health care practitioners feel uncertain about the legal consequences for either adhering to the DNAR order or ignoring it.

Very little research has been done to address the dilemma of DNAR orders in the pre-hospital environment and the legal effect thereof on emergency health care practitioners, especially in South Africa.

A comparative study was done with the Unites States of America and the United Kingdom. The literature on research done in the USA and the UK provided clarity regarding the guidelines and legislation used in order to address DNAR orders as well as the possible legal and ethical dilemmas posed by the use of guidelines and legislation. This provided a possible solution for South Africa and with which known dilemmas can be addressed proactively instead of reactively.

In conclusion, it was found that there is a need to allow the use of DNAR orders, which has to be regulated. Proposed legislation, focussing specifically on the pre-hospital environment and DNAR orders, is included in the study. It is furthermore suggested that proper guidelines should be developed from the proposed legislation, to be approved by the Minister of Health, in order to provide clarity for health care practitioners, on the use and enforcement of DNAR orders.

Key terms: DNAR order, pre-hospital, ethical principles, legislation, emergency, health care practitioner

DECLARATION

“I, Charné Viljoen, declare that the Master’s Degree research dissertation that I herewith submit for the Master’s Degree qualification Magister Legum at the University of the Free State is my independent work, and that I have not previously submitted it for a qualification at another institution of higher education.”

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Charné Viljoen

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1. INTRODUCTION

1.1 PRE-HOSPITAL CARE

Pre-hospital care can be described as any initial medical care given to an ill or injured patient by a paramedic or any other trained emergency health care practitioner before the patient reaches the emergency department of a health care facility.[1]

Pre-hospital care can involve any of the following interventions: basic life support as well as intermediate- and advanced life support. In some cases, it may only consist of comfort and reassurance. Advanced life support includes, but is not limited to spinal immobilization, airway protection, endotracheal intubation, intravenous therapy, medication administration, defibrillation and other advanced interventions.[2]

For this study, the focus will be on care given in cardiac[3] emergencies.

Consider the following scenario:

You are a trained and registered health care practitioner. You are called to the residence of a male of a high age. Upon arrival at his home you find him in a semi sitting position in his bed. His wife and son are also present. He complains about chest pains and shortness of breath.

You initiate your treatment by taking his vital signs such as blood pressure, heart rate, respiration rate, blood glucose level and oxygen (O2) saturation levels. While you are busy with your treatment he lets out a moan and collapses. You attach the pads of the electrocardiography (ECG) machine to check for a shockable rhythm and the ECG indicates that he is in cardiac arrest. Since this was a witnessed cardiac arrest you check for a shockable rhythm, you find that there is no shockable rhythm present and you place the patient on a firm surface to initiate the protocol for cardiac arrest, which is one man Cardio Pulmonary Resuscitation (CPR), since you are the only registered health care practitioner at the scene.

1 http://medical-dictionary.thefreedictionary.com/pre-hospital+care (accessed on 10 June 2017).

2 Sanders 2010:7.

3 Concerning the heart.

As soon as you initiate CPR the wife verbally informs you that the patient has a Do Not Attempt to Resuscitate order (DNAR). The son however indicates that he has no knowledge of such an order. You request a written document, but the wife informs you that she cannot find the document.

As a health care practitioner, you are faced with two options in the above-mentioned scenario.

The first being that you can continue with the treatment of one man CPR, which you have initiated, until the written document is found. Otherwise, until the patient has spontaneous return of circulation, meaning that the patient has a palpable heartbeat.

The second option is to terminate the initiated CPR and take the word of the wife that there is a written DNAR order somewhere in the house.

Both these options tend to leave one with a rather uneasy feeling, not certain of how one will be protected by law and also from the repercussions of the Health Professions Council of South Africa (HPCSA).

1.2 AIM OF STUDY

This study aims to clarify what measures should be taken in a life-threatening emergency event where cardiopulmonary resuscitation (CPR) or a component of CPR is required and also initiated by an emergency health care practitioner, but soon after the initiation of CPR s/he is informed, by a bystander, usually a family member, that there is a DNAR order in place, but no written proof of a DNAR order can be found. Should the emergency health care practitioner continue with CPR or should s/he adhere to the verbal DNAR? What would the legal and ethical consequences be for the emergency health care practitioner who follows either one of the options mentioned?

This research topic stands at the intersection of medical law, criminal law, law of delict and the ethical principles of medicine. Should legislation or guidelines be developed for the regulation and enforcement of health care advance directives, more specifically DNAR orders? Also, will an emergency health care practitioner be held criminally liable for ignoring a DNAR order, when there is no written proof presented - and be accused of assault? And also, not adhering to the patient's wishes and thereby ignoring the ethical

principle of patient autonomy. And lastly, if the emergency health care practitioner adheres to the DNAR order, when there is no written proof presented, should s/he be held liable for negligence?

Through research, this study aims to clarify and focus on the use of health care advance directives, more specifically DNAR orders, in the pre-hospital context and the possible development of legislation for the enforcement and regulation thereof. As part of the study, a comparison to other countries will be made.

Section 8(3)(b) of the Constitution of the Republic of South Africa of 1996 provides that when a provision of the Bill of Rights is applied to a natural or juristic person, a court may in order to give effect to a right in the Bill, apply, or if necessary develop the common law to the extent where legislation does not give effect to that right. Furthermore, s39 also provides that when the Bill of Rights is to be interpreted, a court must consider international law and may consider foreign law. Also, when developing the common law or customary law, every court must promote the spirit, purport and objects of the Bill of Rights. To find a common ground to which a comparison can be made and which has proper reason to feature as a common ground the International Liaison Committee on Resuscitation was chosen.

The International Liaison Committee on Resuscitation (ILCOR) was established in 1992 to create and provide a forum for liaison between key resuscitation organisations worldwide. As part of being a member to the ILCOR, each organisation accepted the obligation, upon becoming a member, to create new resuscitation guidelines.[4]

Current members of the ILCOR are, amongst others, the American Heart Association (AHA), the European Resuscitation Council (ERC), the Resuscitation Councils of Southern Africa (RCSA) and the Inter American Heart Foundation (IAHF).

In South Africa, any health care advance directive does not enjoy legal recognition,[5] thus creating a health care advance directive does not give the patient peace of mind nor does it give the health care practitioner certainty that should s/he adhere to the health care advance directive that s/he would be shielded from any persecution. This study aims to

4 http://www.ilcor.org/about-ilcor/about-ilcor// (accessed on 13 September 2017).

5 McQuoid-Mason 2013:224.

identify the need to create guidelines for the recognition of health care advance directives and in particular DNAR orders.

To find guidance regarding health care advance directives, a comparison will be done between South Africa, the United States and the United Kingdom. The ILCOR serves as the link tying the comparisons together since all three countries are members of the ILCOR and relates directly to the topic at hand focussing on resuscitation and the refusal thereof.

1.3 CHAPTER OVERVIEW

Through this study, the aim is to identify the legal position of an emergency health care practitioner regarding Do Not Attempt to Resuscitate orders. To provide a clear understanding of clinical definitions and terms used, Chapter 2 provides an overview of medical and clinical definitions and terms used in this study. Also included in Chapter 2 is a brief overview of the history of emergency medical care in the world as well as South Africa. The levels of emergency medical care provided by registered emergency health care practitioners are identified and explained briefly along with the basic functions of emergency medical care in order to understand the context of emergency medical care in South Africa.

The first country, the United States of America, to be compared with is identified in Chapter 3, where the legal position of patients, regarding their right to decision making relating to their health care, is identified and explained. Legislation and case law will be used in order to achieve this. Focus is placed on the consequences, for health care practitioners, should they ignore a patient's Do Not Attempt to Resuscitate order. Working modules and obstacles are identified and compared to possible use in South Africa.

Following Chapter 3, Chapter 4 analyses the legal position of patients, regarding their right to decision making relating to their health care, in the United Kingdom. Each nation, England, Wales, Scotland and Northern Ireland, is analysed separately. As there is no concrete legislation, an analysis of the guidelines for Do Not Attempt to Resuscitate orders was done. A separate analysis of court cases relating to Do Not Attempt to Resuscitate orders was done in order to identify the effectiveness of the guidelines used in the United Kingdom.

Chapter 5 focusses specifically on the legal position of Do Not Attempt to Resuscitate orders in South Africa via an analysis of the patient's right to refuse medical treatment in terms of the Constitution of the Republic of South Africa. Furthermore, the legal position of the health care practitioner both criminally and delictually was done in order to determine whether a Do Not Attempt to Resuscitate order could lead to liability of a health care practitioner either criminally or delictually. Case law relating to end of life decisions were also analysed in order to identify the need for the recognition of Do Not Attempt to Resuscitate orders. Brief reference is made to the End of Life Decisions Bill as it also made reference to the right of patients to make their own decisions regarding their health care. Lastly, an analysis of the regulatory powers of the Health Professions Council of South Africa along with the Professional Board of Emergency Care is done in order to determine the health care practitioner's position relating to Do Not Attempt to Resuscitate Orders.

Core ethical principles and the law are discussed in Chapter 6 in order to identify the core ethical principles relating to the health care profession and to provide methods as to how ethical dilemmas can be resolved. An analysis of the relevant legislation was done along with how these pieces of legislation give effect to the core ethical principles in order to indicate that core ethical principles have a legal stance in the health care profession.

In light of the above, it was possible to identify dilemmas relating to DNAR orders in Chapter 7 as well as to provide possible solutions to each of these dilemmas.

2. CLINICAL CONCEPTS AND A HISTORY OF BACKGROUND TO EMERGENCY MEDICAL CARE

2.1 INTRODUCTION

This chapter aims to provide a brief explanation of terms used in this study as well as what certain treatments consist of. A brief history and layout of emergency medical care will also be presented.

The crux of this study focusses on Do Not Attempt to Resuscitate (DNAR) orders, which thus represent the beginning of the explanation.

2.2 DEFINITIONS AND DESCRIPTIONS

2.2.1 Health care advance directive

A health care advance directive can be a written document or communicated verbally. A health care advance directive communicates the thoughts, wishes, or preferences for health care decisions, when the patient is unable to communicate them due to incapacity.[6] A health care advance directive encompasses written directives such as DNAR orders, living wills and durable power of attorney for health care.

2.2.2 Do Not Attempt to Resuscitate order

A Do Not Attempt to Resuscitate (DNAR) order is a written health care directive given by a registered health care practitioner, specifically a physician, where the patient requested to have a DNAR order written and added to his/her file. A DNAR order simply put means "do not call a code or perform CPR when the patient's heart stops beating, or lungs stop breathing".[7]

Why DNAR and not simply DNR? One could argue that DNR and DNAR represent the same term or concept, but a DNAR uses more clear language to indicate that only a resuscitation attempt should be withheld, whether the attempt is likely to succeed or not.[8]

6 https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines--2/ (accessed on 16 June 2017).

7 Breault 2011:302.

8 Breault 2011:303.

A DNAR order does not indicate that other end of life care such as comfort care and pain relief should be withheld; only that treatments such as intubation, ventilation or vasopressor support should not be provided. To laymen, it is often unclear as to whether it also means Do Not Treat, unless this is explicitly clarified in good communication between the patient and the attending physician or even clearly stated in the DNAR order. If not clarified, the patient's family may think that oxygen, intravenous fluid, antibiotics etc. are part of the "resuscitation" and their loved one will not receive them.[9]

Allow Natural Death (AND) means that the patient would like to let nature take its course, without CPR interventions to be initiated in the event where CPR is unlikely to succeed.[10] Lately, some Healthcare facilities would rather opt to use the term AND rather than DNAR due to the fact that DNAR orders are frequently incorrectly interpreted as the refusal of or the withdrawal of all end of life care including comfort care.

For this study, when referring to a DNAR order it means that the DNAR order does not indicate that other end of life care such as comfort care and pain relief should be withheld; only that treatments such as intubation, ventilation, CPR or vasopressor support should not be provided.

2.2.3 Cardiac arrest

Cardiac arrest is the absence of a pulse, blood pressure and respirations.[11] According to the American Heart Association, a cardiac arrest is the abrupt loss of heart function in a person who may or may not have a diagnosed heart disease. It is an unexpected event and it occurs instantly or shortly after symptoms appear.[12] A cardiac arrest requires immediate medical intervention to avoid death.

2.2.4 Cardiopulmonary Resuscitation

Cardiopulmonary refers to terms relating to the heart and lungs.[13]

9 http://www.acphospitalist.org/archives/2009/10/status.htm (accessed on 21 July 2017).

10 Breault 2011:303.

11 Grudzen, Koenig, Hoffman, Boscardin, Lorenz and Asch 2009:170.

12 http://www.heart.org/HEARTORG/Conditions/More/CardiacArrest/About-Cardiac-Arrest_UCM_307905_Article.jsp#.WUVNZWiGPIUU (accessed on 17 June 2017).

13 Stedman 2005:237.

Resuscitation refers to the technique one uses in attempts to return spontaneous pulse and breathing to a patient and includes interventions such as oxygen and airway management, insertion of an intravenous line to administer drugs or intravenous fluids, manual chest compressions and the administration of electrical therapy.[14]

CPR with the use of Advanced Cardiac Life Support (ACLS) includes medication administration, and/or an attempt at intubation. ACLS medications include epinephrine, atropine, sodium bicarbonate, calcium chloride and amiodarone. Chest compressions also form part of CPR.

CPR is a series of lifesaving actions that improve the chance of survival after cardiac arrest. Although the optimal approach to CPR may vary, depending on the rescuer, the patient, and the available resources, the fundamental challenge remains how to achieve early and effective CPR.[15]

The techniques of CPR have been routinely applied for victims of cardiopulmonary arrest in inpatient and outpatient settings since the mid-1960's when CPR was first formally introduced. With advances being made in medicine, one should consider a patient's autonomy and respect the decision not to want such medical interventions. Thus, not long after CPR was introduced, DNAR orders also became known. The aim of the DNAR order was and still is to avoid the indiscriminate application of resuscitative efforts for patients who were hopelessly ill with little chance of ultimate survival. The applicability of these early DNAR orders was generally limited to institutional settings in which specific policies for their use had been developed.[16] There has been a growing recognition that a similar acknowledgement of DNAR orders in the pre-hospital setting is necessary to ensure that morally and medically appropriate interventions are provided by emergency health care practitioners.[17]

14 Sanders 2012:712.

15 American Heart Association: Advanced Cardiovascular Life Support 2016:13.

16 Leon and Wilson 1999:263.

17 Koenig and Tamkin 1993:51; Crimmins 1990:47.

2.3 HISTORY OF EMERGENCY MEDICAL CARE

Organized pre-hospital emergency care has its roots in military history. The first civilian ambulance services were established in Cincinnati and New York City in the 1860s.[18]

World Wars I and II were two of the major contributors to pre-hospital emergency care when machine guns and bombs came in to use. From thereon, several landmark developments can be found relating to pre-hospital emergency care. In the mid-1950s, the first training program for ambulance attendants was created by the American College of Surgeons.

In the 1960's, cardiopulmonary resuscitation was shown to be effective. In 1970, The National Registry of Emergency Medical Technicians in the United States of America was organized in order to standardize the education, examinations and certification of Emergency Medical Technicians at national level. The blue star of life was adopted as the official symbol for Emergency Medical Services in 1973 and in 1975 the American Medical Association accepted and approved the Paramedic's role as an emergency health occupation.[19]

For South Africa, the so-called ambulance services and firefighting services were combined into one service since 1910 as part of the Act of Union,[20] given that the provision of health and hospital services now fell under local authority, meaning the responsibility of each Central and/or Provincial Government. The ambulance component of these services was not always up to standard and lacked in proper equipment and training.[21]

In the 1960s, the Ambulance Services of the Western Cape were regionalised and placed under the control of a medical director; this lead to numerous improvements and advances that can still be noticed of the Western Cape emergency services - especially in disaster management.[22]

18 Sanders 2012:2.

19 Sanders 2012:7.

20 *The Union of South Africa Act* 1910: sec 85(v).

21 Dalbock 1996:118.

22 Dalbock 1996:119.

In the 1970s, the Ambulance Services were placed under the responsibility of the Health Departments of the Provincial Administrator under section 16 of the Health Act 63 of 1977. Through this, Provincial Ambulance Training Colleges were established along with upgrades in ambulance design and rescue training. Communication networks were upgraded and investigation into Advanced Life Support training began.[23]

By the 1980s, there were trained advanced life support practitioners, standards of care improved, and rescue services were compatible with international norms.

Each province had now created their standards and norms, but no national standards or norms existed. To address this matter, the Professional Board for Emergency Care Personnel (PBEC) was established on 10 January 1992. The PBEC, together with the HPCSA, brought about a national scope of practice for all ambulance practitioners as well as ethical rules and nationally standardized training and protocols. A register for each level of emergency health care practitioner was also established.

2.4 LEVELS OF PRE-HOSPITAL CARE IN SOUTH AFRICA

Along with the nationally standardized trying protocols, a National Diploma in Ambulance and Emergency Care Technology was also established, and the University of the Witwatersrand and Natal Technicon (as it was then known) were among the first to offer the national diploma. This National Diploma is in the process of being phased out and the final pipeline students are to register before 1 February 2018 as per instruction from the Department of National Health along with the HPCSA.

From there on, a B.Tech degree in emergency care was established to be enrolled for after a National Diploma in Emergency Medical Care was obtained. The most recent is the B.EMC degree, which is a full-time, four-year degree, first offered by the Cape Peninsula University of Technology. One can also obtain a Master's and a Doctorate degree in emergency medical care.[24], [25]

23 Dalbock 1996:119.

24 http://www.hpcsa.co.za/PBEmergencyCare (accessed on 5 October 2017).

25 https://www.uj.ac.za/studyatUJ/Pages/post-grad.aspx (accessed on 1 October 2017).

In South Africa, the levels of pre-hospital health care, also referred to as emergency medical services (EMS), can be divided into three levels of health care; namely, basic life support; intermediate life support, more commonly known as medics, and then lastly, advanced life support, also known as paramedics.

Each level of care follows a specific protocol and scope of practice, as determined by the HPCSA.

2.4.1 Basic Life Support

At Basic Life Support level, one obtains a Basic Ambulance Assistant (BAA) certificate and register with the HPCSA as a supervised practitioner.

At this level of care, the health care practitioner can only withhold CPR when the body was decapitated, mortal disfigurement is present, or putrefaction is present and when there are obvious signs of *rigor mortis*[26] or the presence of post mortem lividity.[27]

2.4.2 Intermediate Life Support

At Intermediate Life Support level, one obtains an Ambulance Emergency Assistant (AEA) certificate and register with the HPCSA as an independent practitioner, with a pre-determined scope of practice.

At this level of care, the health care practitioner can withhold CPR when the body was decapitated or mortally disfigured, when there is *rigor mortis,* putrefaction of the body or lastly when post mortem lividity is present.

An Intermediate Life Support health care practitioner can also declare a person dead when there is no evidence of cardiac electrical activity on an electrocardiogram in all three leads for 30 seconds or more. Another instance for the declaration of death is possible is when there are no palpable central pulses and no audible heart sounds. Both

26 *Rigor mortis* can be understood as the rigid stiffening of skeletal and cardiac muscle shortly after death.

27 HPCSA Intermediate Life Support Practitioner Guidelines 2006.

pupils should be fixed and dilated and no spontaneous breathing for the past 5 minutes along with no oculocephalic reflex[28] and the absence of gag and corneal reflexes.[29]

2.4.3 Advanced Life Support

At Advanced Life Support level, one can either obtain either a Critical Care Assistant (CCA) Certificate or a National Diploma after which one will be known as a paramedic. If a Bachelor's in Emergency Medical Care was obtained, one will be known as an Emergency Care Practitioner. All individuals with these qualifications operate at advanced life support level and are registered as independent practitioners with the HPCSA, each with their respective predetermined scope of practice.

Although operating at the highest-level, ALS practitioners can still only declare a person dead and not certify the death of a person.

The protocol for declaration is similar to the protocol for ILS.

2.5 FUNCTIONS OF EMERGENCY MEDICAL CARE

The blue star of life representing emergency medical care was created so that each point of the six-pointed star resembles a function of emergency medical care. Irrespective of the level of care, the six functions of emergency medical care are:[30]

Detection – early detection of an incident is important, as the initial detection of a possible emergency is the first step to be taken in order to seek the necessary help.

Reporting – Once the emergency has been detected, it should be reported to the relevant authorities so that the correct level of care is dispatched.

Response – After an emergency is reported, an emergency medical team will be dispatched to the location of the emergency; this is done via response in which the team attempts to reach the scene as quickly as possible with the provided caution.

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28 To determine whether a patient's brainstem is still intact oculocephalic reflexes are used. While keeping the patient's eyes open the patients head should be rotated form side to side. Once the head is tilted to the side the eye movement should be recorded. An intact brainstem would have the response that the eye rotates to the opposite side to the direction the head of the patient is rotated.

29 HPCSA Intermediate Life Support Practitioner Guidelines 2006:21.

30 http://www.fcems.org/EMS-purpose.html (accessed on 25 September 2017).

On scene care – The dispatched emergency medical team will provide the best possible care at the scene and call for a higher level of care for backup should it be necessary.

Care in transit – Once the patient has been loaded into the ambulance to be transported, the patient care does not stop. One member of the emergency medical team will drive the vehicle, usually the lower qualified of the two, and the other member will stay in the back of the vehicle with the patient in order to ensure that the interventions that took place are still effective. The aim is always to keep the patient in the same condition or to improve the condition.

Transfer to definitive care – once the patient has been transported to a receiving health care facility, the patient will be handed over to the receiving medical staff along with all relevant patient information.

2.6 GENERAL REMARKS

Health care practitioners refer to all persons qualified to be registered with the HPCSA. For the purpose of this study, a health care practitioner will refer to a physician as well as all the levels of emergency health care practitioners, more generally known as medics or paramedics.

An Emergency Care Practitioner (ECP) is considered a person with a Bachelor's degree in emergency medical care. For the purpose of this study, the general referral will be to a health care practitioner, however when emphasis is being made to the emergency health care practitioner, s/he will be referred to as an emergency health care practitioner, which will include all levels of emergency health care practitioners, more generally known as medics or paramedics.

3. THE UNITED STATES AND HEALTH CARE ADVANCE DIRECTIVES

The right to a good death is a basic human freedom. The Supreme Court's decision to uphold aid in dying allows us to view and act on death as a dignified moral and godly choice for those suffering with terminal illnesses – John Shelby Spong

3.1 INTRODUCTION

Health care advance directives, especially DNAR orders, are not new to South Africa, but it is not a concept that has so far been explored enough to provide legal and ethical certainty. In order to shed a clearer light on DNAR orders, one needs to consult external sources where DNAR orders are implemented and enforced.

South Africa is a member of the International Liaison Committee on Resuscitation (ILCOR).[31] ILCOR provides a forum for liaison between principal resuscitation organisations worldwide.[32] The Resuscitation Council of Southern Africa as well as the American Heart Association (AHA) of the United States of America forms part of ILCOR. Each council submits guideline proposals to ILCOR in order to keep abreast of advances made in medicine and best practices. ILCOR provides a suitable comparative platform for the comparison in this study between the legal position, or lack thereof, in South Africa and the United States of America.

3.2 THE PATIENT SELF-DETERMINATION ACT

In 1990, in a landmark case *Cruzan v Missouri Department of Health*[33] it was found, by the Supreme Court of the United States of America, that a Patient Self-Determination Act (PSDA)[34] should be developed. This was to reinforce the constitutional right of an individual to make medical decisions since a competent person has a liberty interest under the Due Process Clause, as stated in the Fifth and Fourteenth Amendment Act of

31 http://emssa.org.za/plea-to-the-south-african-public-its-time-to-learn-cpr/ (accessed on 25 May 2017).

32 http://www.ilcor.org/about-ilcor/about-ilcor/ (accessed on 26 May 2016).

33 *Cruzan v Missouri Department of Health* 497 U.S. 261 (1990).

34 *Federal Patient Self Determination Act* 1990 42 U.S.C. 1395 cc (a).

the Constitution of the United States of America, in refusing unwanted medical treatment.[35] The Fifth Amendment states that no one shall be "deprived of life, liberty or property without due process of law".[36] The Fourteenth Amendment also state it as such.

The PSDA is important because it reinforces the patient's ability to make their final wishes for medical care known, and it offers an added layer of protection to the various state statutes on living wills. Furthermore, the term "wrongful prolongation of life" has become a rather frequently used term in legal debates due to the increasing number of claims in recent years where the term "wrongful prolongation of life" has been used to recover damages. In these cases, the "wrongful prolongation of life" has required a close look at state and federal laws, of the United States of America, regarding death, living wills and health care advance directives.[37]

After the implementation of the PSDA in 1990, *Wright v. Johns Hopkins Health Systems*[38] drew attention, once again, to a state's law regarding health care advance directives.[39] This Maryland case involved an individual with Acquired Immune Deficiency Syndrome (AIDS) who was resuscitated after a cardiac arrest. The deceased's parents and executor of his estate sued the health care practitioners, claiming they "wrongfully prolonged the patient's life" when he had a living will that stated his desire for no resuscitation. Ultimately, the court noted that the patient's statements in the emergency room about a DNAR order were insufficient and not viable to represent a form of a living will or DNAR. The court skirted the issue of "wrongful prolongation of life" by denying the claim for damages on other grounds and concluded that it is up to the legislature to decide whether "wrongful prolongation of life" is a proper delictual claim.[40] Apart from emphasizing the fact that claims are made based on the "wrongful prolongation of life", this court case can also be used to emphasize the need for a standardization of a system where DNAR's will be introduced and the obtainment thereof made available to patients. Furthermore, also allowing for the recognition and implementation of a DNAR order.

35 *Cruzan v Missouri Department of Health.*

36 https://www.law.cornell.edu/wex/due_process (accessed 23 January 2017).

37 Saitta and Hodge 2013:452.

38 *Wright v. Johns Hopkins Health Systems* 728 A.2d 166 (Md. 1999).

39 Saitta and Hodge 2013:453.

40 Saitta and Hodge 2013:454.

3.3 WHAT ARE THE CONSEQUENCES OF DISREGARDING A "DO NOT ATTEMT TO RESUSCUTATE" DIRECTIVE IN THE UNITED STATES OF AMERICA?

In 1990, the case of *Cruzan v Missouri Department of Health 497 U.S. 261 (1990)* was heard before the United States Supreme Court. The Court recognized the right to die, given effect by the Fourteenth Amendment, from which a person can refuse unwanted medical treatment. This means that a patient has the right to refuse life-sustaining medical procedures. The USA values the constitutional right to die and the claim to the "wrongful prolongation of life" is inextricably linked to this constitutionally protected right in the USA.[41]

The reported decisions delivered by the courts in the USA in cases of "wrongful prolongation of life" reflect a general finding by the courts that it is not their duty to judge an impaired life as being inherently less valuable than non-life. Based on these findings, a general reluctance by the courts appear when it comes to granting monetary compensation, especially for claims in respect of damages suffered due to pain and suffering.[42]

In 1976, health care advance directives and the prolongation of life became a public issue with the case of Karen Ann Quinlan.[43],[44] This case is viewed as one of the first concerning "the right to die" and the court rightfully noted the concern regarding the so called "prolongation of life" and the lack of legislation in this area,[45] very much the same position where we find ourselves currently in South Africa, although it is a few decades later.

The litigation in the *Quinlan* case paved the way for future court cases. In this particular case, the father of a 21-year-old daughter in a persistent vegetative state sought guardianship in order to discontinue all extraordinary life-sustaining procedures. This provided legal grounds to issue declaratory or injunctive relief against health care practitioners who refuse to carry out health care advance directives. Should a person be forced to live a life which s/he would not want to live due to physical impairment after an

41 Saitta and Hodge 2013:442.

42 *Burks v St Joseph's Hospital* 596 N.W.2nd 391 (Wis. 1999).

43 Saitta and Hodge 2013:443.

44 *In Re Quinlan* 70 N.J. 10 (1976) 355 A.2nd 647.

45 Saitta and Hodge 2013:443.

accident or diagnosis of a terminal illness? The *Quinlan* case also led to the enactment of state statutes which aim to protect a patient's right to die while upholding a health care practitioner's obligation to prolong life.[46] The current South African position can be compared to this as Fabricius J ruled in *Stransham-Ford v Minister of Justice and Correctional Services and Others* [47] in favour of the applicant allowing terminally ill patients to end their lives by means of assisted suicide. This ruling was overturned in the Supreme Court of Appeal in 2016, which reverts SA back to square one when it comes to the patient's right to die.

From the above, it is submitted that legislation should be developed in order to regulate the use of health care advance directives, including DNAR orders. It is not conducive to the proper administration of justice for the courts to piecemeal develop the law by having to decide on the merits of each individual case it is confronted with. This method puts unnecessary strain on the courts and makes relief available to the privileged few who can afford litigation. It also does nothing for legal certainty. Hence, legislation is a much simpler and effective answer to the problem.

The ethical dilemma, even with the presence of a health care advance directive and/or a DNAR order but no legislation or guidelines, is honouring health care advance directives while also acting in the best interest of the patient. After the court ruling of *Quinlan,*[48] many state laws attempted to addresses this dilemma.[49] The majority of the legislation developed to give effect to living wills, durable powers of attorney, or health care proxies also contained clauses which permit health care professionals to disregard a patient's or family's wishes due to the health care professionals' personal beliefs. This, however, is not a solution as it develops uncertainty for the patient.

46 Saitta and Hodge 2013:443.

47 *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP).

48 *In Re Quinlan*

49 Swartz 2006:282-283.

At least seventeen states specifically mention the word “liability” regarding treating patients with health care advance directives, either by the administering of treatment or the following of a DNAR order.[50]

The annotated general laws of Massachusetts represent one of the statutes which do not hold the health care practitioner criminally or civilly liable for removing life support in the presence of a health care advance directive.[51]

Statutes appear to contain a general language such as “the physician shall use his/her best judgement when delivering a standard of care”.[52] Thus, if a health care practitioner ignores a health care advance directive under the pretence of following a certain standard of care, the health care practitioner will not be held liable for disregarding the health care advance directive thereof.[53]

Some States’ statutes do mention civil and/or criminal liability.[54] The language contained in these statutes seems intentionally vague, allowing the health care practitioner to comply with health care advance directives without liability, while also protecting them if they do not act in accordance with a patient’s directive, but within “reasonable medical standards”. It is clear that these statutes recognize the existence of health care advance directives, but there is a disconnection between what the law requires and a health care practitioner’s actual practice, which can cause legal uncertainty and confusion as well as ethical dilemmas.

A big challenge is the paperwork of a health care advance directive and more specifically a DNAR order, specifically the process of having a DNAR order written and registered. Furthermore, paper is a burden to carry around and therefore, to ease the burden, some states provide the option of wearing a “Do Not Resuscitate” bracelet to inform health care

50 These include: Oklahoma, Tennessee, Texas, Virginia, Washington, Puerto Rico, Arizona, Connecticut, Florida, Georgia, Kentucky, Louisiana, Massachusetts, Michigan, Missouri, Nevada and New York.

51 Massachusetts General Laws Annotated. Chapter 201D.

52 These include: Arizona, Colorado, Connecticut, Florida, Georgia, Iowa, Kentucky, Louisiana, Massachusetts, Mississippi, Nebraska, Nevada, New York, Ohio, Oklahoma, Rhode Islands, Tennessee, Texas, Virginia, Washington, Wisconsin and the Virgin Islands.

53 Saitta and Hodge 2013:445.

54 These include: Arizona, Colorado, Connecticut, Florida, Georgia, Iowa, Kentucky, Louisiana, Massachusetts, Mississippi, Nebraska, Nevada, New York, Ohio, Oklahoma, Rhode Islands, Tennessee, Texas, Virginia, Washington, Wisconsin and the Virgin Islands.

practitioners of a patient's resuscitative choice. In Pennsylvania, the Department of Health of the Commonwealth supplies a "Pre-hospital DNAR bracelet" that is issued by the attending health care practitioner. This is worn by the patient to notify emergency health care practitioners of the presence of an order.[55]

Wisconsin allows physicians to provide a DNR order in the form of a DNAR bracelet for adults with terminal illnesses who choose not to receive CPR. Montana and the District of Columbia as well as Virginia also use DNAR bracelets to notify emergency health care practitioners of a DNAR order. Wisconsin also allows for the removal or destruction of a DNAR bracelet by the patient, which is considered a revocation of the DNAR order. While DNAR bracelets may help to communicate a patient's final wishes, most of these measures are aimed at alerting EMS first-responders.[56] Should a person not be wearing the DNAR bracelet upon arrival of the EMS first-responders, these EMS first-responders cannot be held liable in the event where CPR was needed and initiated.

A study was done on the potential impact of a verbal pre-hospital DNAR order policy. Two locations were identified where verbal DNAR orders are acknowledged, the one being King County, Washington and the other being Los Angeles County.[57]

Although forgoing resuscitation in the event of cardiac arrest usually required a written pre-hospital DNAR order, some emergency medical services, as already mentioned, have implemented policies allowing surrogate decision makers to verbally request to forgo resuscitation, without a written DNAR order being present.[58]

It is uncommon to find a written DNAR order in the pre-hospital setting as a reason to forego resuscitation. Even in the event where family members state that the patient has a DNAR order, it happens that the patient will be resuscitated. The study found that nine out of ten times a patient was resuscitated with a DNAR order, but the family member could not provide the necessary paperwork.[59] According to the study, the majority of cardiac arrests happen at home, where emergency health care practitioners find

55 Saitta and Hodge 2013:447.

56 Saitta and Hodge 2013:447.

57 Grudzen *et al* 2009:170.

58 Grudzen *et al* 2009:169.

59 Grudzen *et al* 2009:171.

themselves in the presence of the patient, who is in cardiac arrest, as well as family members. In many cases, the family member would be able to inform the emergency health care practitioner about the patient's wishes regarding end of life decisions.[60]

In most cases, people indicate that they would prefer to die at home, but according to statistics the majority of people actually die in acute care health care facilities, in some cases due to unsuccessful field resuscitation, which only prolonged the inevitable. It is understandable that no person would like to be resuscitated to a state of severe neurologic impairment, which is quite possible after resuscitation - especially in the instance where someone might be chronically ill.[61]

Patients may in some instances indicate their end of life preferences to a surrogate decision maker; these preferences do not always end up being recorded as legal documents. Furthermore, legal documents cannot always be easily located by emergency health care practitioners in the event of a life-threatening emergency. Without knowing the patient's wishes and the duty to provide care, resuscitation will be initiated, which will in fact be against the wishes of the patient. The resuscitation effort can also lead to a chronic non-functional state, which one could consider as one of the main reasons why the patient would have initially made his/her preference known regarding end of life decisions.[62]

As indicated, a large number of states have implemented written pre-hospital DNAR policies which give effect to the Patient Self Determination Act.[63] This allows patients to forego resuscitation outside the health care facility. In King County, Washington and Los Angeles County, paramedics are allowed to forego resuscitation for a terminally ill patient who made a verbal request to a family member; this is allowed even in the absence of a written document. Also, surrogate decision makers are allowed to verbally request that emergency health care practitioners forego resuscitation for a terminally ill patient.[64]

60 Grudzen *et al* 2009:169.

61 Lockhart *et al* 2001:299; Ditto *et al* 1996:332; Grudzen *et al* 2009:169.

62 Grudzen *et al* 2009:169.

63 *Federal Patient Self Determination Act* 1990 42 U.S.C. 1395 cc (a).

64 Grudzen *et al* 2009:170.

To avoid the potential abuse or harm to patients when instituting a verbal DNAR policy, it was decided that, should there be a disagreement among family members relating to the legitimacy of the relationship between the patient and the person verbally requesting to forego resuscitation, it is advised that the patient be resuscitated and transported to the nearest health care facility.[65]

A verbal DNAR order would not be recommended for South Africa, since this does not resolve the paperwork issue and it poses the possibility for abuse. South Africa is a multilingual country which also creates a hindrance when considering the use of a verbal DNAR order. Thus, another means, such as the DNAR bracelet system, should rather be considered.

3.4 WHY ARE HEALTH CARE ADVANCE DIRECTIVES EITHER IGNORED OR MISINTERPRETED IN THE UNITED STATES OF AMERICA?

Although legally there is legal recognition for a person's right to create a health care advance directive and a DNAR order, there may always be the possibly in the back of the person's mind that this health care advance directive will not be honoured, which can in turn lead to a person living an 'unwanted' life. Numerous reasons exist why health care advance directives and DNAR orders may be ignored. One of the main reasons can be attributed to communication errors between physicians, patients and family members of the patient. The fear of reprisal from family members when following such instructions weighs heavily on doctors' minds. This leads to health care practitioners rather not following a patient's health care advance directive in order to avoid a lawsuit. This is a misconception on the part of the health care practitioner; the reason being that if a properly executed health care advance directive or DNAR order is presented by a patient, no family member can overrule this decision made by the patient.[66]

In the matter of *Allore v Flower Hospital*[67] the patient, Mr Allore's, living will was ignored by a health care practitioner who initiated life sustaining treatment, although the patient explicitly refused such treatment in his health care advance directive contained in his

65 Grudzen *et al* 2009:172.

66 https://physiciansnews.com/1999/09/14/liability-for-failing-to-follow-advance-directives (accessed on 25 March 2017).

67 *Allore v Flower Hospital* 699 N.E.2d 560, 561- 62 (Ohio Ct. App. 1997).

living will. Due to numerous admissions, the paperwork of his living will was not carried over as it should have been and thus the treating health care practitioner was unaware of the health care advance directive refusing life sustaining treatment. In this matter, the court decided that the recovery for medical costs and pain and suffering could not be awarded. This was decided under the doctrine of implied consent, a policy which protects health care practitioners when providing treatment in emergencies "without the spectre of liability for lack of consent."[68] 'Luckily' the policy of the doctrine of implied consent, which only finds application in emergency life threatening situations, is not applicable when a health care advance directive exists, since an individual has already made a choice regarding life-sustaining measures. However, a health care practitioner can still act within means of a standard of care, especially when a health care advance directive is not clearly known.[69] Thus, a health care practitioner will be protected in the event where a patient's family member, without the necessary power of attorney, verbally informs the emergency health care practitioner about a DNAR order, and there is no written document as proof.[70] In this instance, the health care practitioner will be allowed to provide all care needed for the patient without the fear of reprisal. The opposite is also applicable. Where a patient might have a living will consisting of a health care advance directive or DNAR order, but this is not available at the time of intervention, then the health care practitioner will be protected by the doctrine of implied consent when they treat the patient.

It appears that the main reasons for health care practitioners ignoring a patient's wishes can be summarised into three categories. Firstly, the fear of liability, which from the above can be concluded to be an incorrect stance. Secondly, the perception that directives interpose a unnecessary additional control over and interference with the health care practitioner's professional action. This can also be an incorrect stance, since health care advance directives give effect to a patient's rights and can also serve as guidelines for health care practitioners when difficult decisions regarding treatment need to be made.

68 Saitta and Hodge 2011:229-230; 2013: 449.

69 Saitta and Hodge 2013:449.

70 To clarify, there should be written proof of a DNAR order if a family member, without power of attorney, informs a health care practitioner about the DNAR. Where the family member does have power of attorney a written DNAR order is not required.

Lastly, the perception that directives implicitly question the health care practitioner's judgement of the patient's best interest.[71]

In this regard health care practitioners are required to assess the severity of the patient's injuries or illness and treat the patient accordingly.[72] Thus, if it appears, after the assessment of the patient's injuries or illness, that the outcome of a resuscitation effort looks poor and a DNAR order is present, then it should be common sense, for a trained health care practitioner, not to resuscitate the person. Instances such as being struck by lightning do exist, where a patient simply needs defibrillation in order to 'restart' the heart since it is in ventricular fibrillation and after defibrillation the patient can make a full recovery. If a DNAR order does exist in such instances, will it be fair to adhere to this? This will be discussed in Chapter 7.

Medicine is not always as easy and straightforward as one would prefer it to be and health care practitioners are often placed between a patient's wishes and medical necessity. This brings another factor that might influence the disregarding of a DNAR order into play, which is the financial motivation to prolong treatment. While a DNAR status may be indicated, the division within the family creates a hostile environment for medical staff. As such, should a cardiac arrest occur, health care practitioners prefer to resuscitate the patient until the family reaches consensus. Thus, it is important to be very specific with end of life directives and to apprise one's family of these decisions.[73]

3.5 THE DEVELOPMENT OF TWO PROTOCOLS IN THE UNITED STATES OF AMERICA AFTER THE IMPLEMENTATION OF THE PATIENT SELF DETERMINATION ACT

3.5.1 Connecticut

In 1987, the Director of the Office of Emergency Medical Services (OEMS) affirmed that the standard of care for a "911" call in the State of Connecticut, which activates emergency services, included that pre-hospital practitioners would start CPR on all

71 Saitta and Hodge 2013:49.

72 Saitta and Hodge 2013:450.

73 Saitta and Hodge 2013:450.

patients in cardiopulmonary arrest.[74] From this it was considered as routine to initiate resuscitative efforts, but it was medical control physicians who had the capacity and authority to direct an emergency health care practitioner to withhold or withdraw any resuscitative efforts for an individual patient, once the patient was in full cardiac arrest. Furthermore, it was also allowed for the patient's physician to issue a DNAR order, once the patient was in full cardiac arrest, should they be present on scene and then be willing to accompany the patient to the hospital.[75]

One of the main problem areas which could be identified in this arrangement was that in most circumstances emergency physicians providing medical control do not know the patient. It rarely happened to be the patient's attending physician who was present at the scene. Furthermore, it is nearly impossible to retrieve medical records in the limited amount of time given in an emergency and contact with the attending physician cannot always be made. Obtaining reliable and certain knowledge of the patient's medical condition and wishes for end of life care is a real challenge in the emergency pre-hospital setting. This causes emergency physicians to be unwilling to issue orders to cease or withhold resuscitation and they typically erred on the side of aggressive intervention pending clarification of a patient's medical status.[76] In this particular setting one does not want to have physicians either not adhering to end of life decisions at all, or have a physician issuing an end of life wish that might not have been there at all.

i. Protocol development

The protocol to be developed had to create a system for the pre-identification of patients, with a mechanism for immediate verification of the DNAR status and the revocation of the DNAR order by the patient had to be possible. Once implemented throughout the state, it was also of priority to educate both healthcare practitioners and patients.[77]

The Connecticut College of Emergency Physicians (CCEP) EMS Committee was of the opinion that new legislative or regulatory mandates were not essential for creating a workable program. From this opinion, the DNAR bracelet program was developed in

74 Leon and Wilson 1999:263.

75 Leon and Wilson 1999:264.

76 Leon and Wilson 1999:264.

77 Leon and Wilson 1999:264.

order to provide a more practical way to ensure that a particular patient's living will was communicated to emergency health care practitioners on scene.[78]

The DNAR bracelet designed by CCEP had a unique symbol stamped on it by the manufacturer and was a means of quick identification. Included with the DNAR bracelet was a packet comprising certain documents. The DNAR bracelet was issued to the patient and the original DNAR order form was kept by the local agency, and copies were sent to the attending physician, the patient, and the local health care facility's emergency department. This packet included a brief statement of purpose, a DNAR order sheet for appropriate signatures, guidelines to be followed by participating agencies distributing DNAR bracelets, guidelines for EMS personnel and a general discussion page outlining the development of the program.[79]

The DNAR bracelet is a health care facility-type, plastic identification band with an insert card that displayed the patient's name and Social Security number, the telephone number of the emergency department at the patient's usual destination health care facility, and the DNAR bracelet expiration date.[80]

ii. Implementation

The pre-hospital DNAR protocol was introduced to emergency medical care personnel at an annual state-wide emergency medical services conference, which was held four months before the anticipated implementation of the protocol.[81] Furthermore, information on the implemented protocol was included in EMS initial and refresher training courses throughout the state.[82]

3.5.2 Columbia

i. Protocol development

The protocol was developed to allow health care practitioners, specifically physicians, to draft pre-hospital DNAR orders on behalf of their patient at the patients' request and after a discussion with the patient, where the consequences were explained. This pre-hospital

78 Leon and Wilson 1999:264.

79 Leon and Wilson 1999:266-267.

80 Leon and Wilson 1999:267.

81 Leon and Wilson 1999:267.

82 Leon and Wilson 1999:268.

DNAR order specifically instructs emergency health care practitioners to withhold resuscitation in the event of cardiac arrest.[83]

The DNAR order is registered with Washington Emergency Medical Services and the signed, dated and stamped original document is returned to the patient to be worn in a specially sealed DNAR bracelet around the patient's wrist. The information in the DNAR bracelet is also available in electronic format on the EMS computer system. Should it happen that the patient suffers a cardiopulmonary arrest in a pre-hospital setting, the health care practitioners will be alerted to look for a DNAR bracelet. Once an intact DNAR bracelet is identified, the health care practitioners will withhold CPR, intubation and other advanced airway management, which can also be described as "life sustaining measures". The health care practitioners may, however, provide comfort care, such as nasal cannula oxygen to the patient.[84]

The DNAR may be revoked by the patient. This can be done by the patient who formally requests the attending physician to rescind the order or otherwise by simply destroying the DNAR bracelet itself.[85]

3.6 CONCLUSION

Advances in medicine does not necessarily mean that each and every person would like to undergo these procedures should the need arise. Due to this view of some patients, "wrongful prolongation of life" litigation is increasingly being instituted by persons and patients who do not wish to receive life sustaining treatment, but it is still given to them irrespective of their wishes. "Wrongful prolongation of life" cases have been advanced under theories of negligence, battery, violations of the Constitution of the United States of America, breach of contract and infliction of emotional distress.[86] Although there are many grounds which could potentially serve as bases for a "wrongful prolongation of life" claim, no real cause of action has emerged with the result of a monetary reward for damages. Although there has been several developments regarding protocols for the use of health care advance directives and specifically DNAR orders, health care

83 Fitzgerald *et al* 1995:224.

84 Fitzgerald *et al* 1995:224.

85 Fitzgerald *et al* 1995:224.

86 Saitta and Hodge 2013:458.

practitioners still remain inconsistent when following these documents. This leads to a dangerous conclusion that although these protocols have been developed, and even legislation in some states, the inconsistency will remain until legislation creates a cause of action for the "wrongful prolongation of life".[87]

Studying literature from the United States of America still provides guidelines when considering the implementation of DNAR orders in South Africa. The Patient Self Determination Act was implemented in 1990 and even before the implementation thereof, some States developed protocols regarding end of life decisions. Learning from both their mistakes and successes, South Africa can build on developing guidelines for the implementation of end of life decisions and more specifically pre-hospital DNAR orders. At this point in the study it is suggested that a protocol be developed by the governing body of health care practitioners, namely the Health Professions Council of South Africa. This protocol should serve as a guideline for the time being, while a national law is developed, similar to the Patient Self Determination Act of the United States of America, which will give effect to a person's decisions regarding end of life decisions.

To avoid confusion and misinterpretation, a DNAR bracelet labelling system would probably be the most effective means to identify a DNAR order. Papers could get lost and be forged and it is not always carried around by the person who created the DNAR order, while a standardised DNAR bracelet would be much easier to identify and be removed, should the patient wish to do so. It will also be more difficult to forge.

To avoid the potential abuse of a newly developed policy, it will be advisable to not consider using a verbal DNAR system. South Africa is a multilingual country which also creates a hindrance when considering the use of a verbal DNAR order. This should be reconsidered once it has been established that abuse is not a major concern when facing end of life decisions.

It is thus important to firstly recognise that the acknowledgement of health care advance directives is much needed in South Africa. Furthermore, protocols and ultimately legislation should be developed to give assured effect to a patient's wishes regarding end of life care, and in addition also an easy method of recognising a DNAR.

87 Saitta and Hodge 2013:458.

4. THE UNITED KINGDOM AND HEALTH CARE ADVANCE DIRECTIVES

To keep someone alive against their wishes is the ultimate indignity - Stephen Hawking

4.1 INTRODUCTION

As was pointed out earlier, health care advance directives, especially DNAR orders, are not new to South Africa, but it is quite a contemporaneous concept as it is also discussed along with decisions relating to the end of life as well as the changing perception of end of life decisions of society. This concept has so far not been explored enough to provide legal and ethical certainty. In order to shed a clearer light on DNAR orders, one needs to consult external sources where DNAR orders are implemented and enforced.

South Africa is a member of the International Liaison Committee on Resuscitation (ILCOR).[88] ILCOR provides a forum for liaison between principal resuscitation organisations worldwide.[89] The Resuscitation Council of Southern Africa and the European Resuscitation Council (ERC) of the United Kingdom form part of ILCOR. Each council submits guideline proposals to ILCOR in order to keep abreast of advances made in medicine, as well as best practices, effecting cardiopulmonary resuscitation. ILCOR provides an apt comparative platform for the comparison in this study between the legal position, or lack thereof, in South Africa and the United Kingdom.

4.2 LEGAL POSITION OF DNAR ORDERS IN THE NATIONS OF THE UNITED KINGDOM

The United Kingdom comprises four nations, namely the whole island of Great Britain – England, Scotland and Wales, and the northern part of Ireland.[90]

88 http://emssa.org.za/plea-to-the-south-african-public-its-time-to-learn-cpr/ (accessed on 25 May 2017).

89 http://www.ilcor.org/about-ilcor/about-ilcor/ (accessed on 26 May 2016).

90 https://www.britannica.com/place/United-Kingdom/ (accessed on 21 September 2017).

4.2.1 England and Wales

England and Wales do not have specific DNAR legislation such as the USA; they do however, have the Mental Capacity Act 2005 that recognises advance decisions to refuse treatment. According to the Act, an advance decision is a decision made by a person older than 18 with the necessary mental capacity. In this decision, the person may specify circumstances in which s/he would like specific medical treatment or refusal of specific treatment.[91]

The Act also provides that a person may, after creating the health care advance directive, withdraw or alter such health care advance directive, with the requirement of full mental capacity.[92] The withdrawal made by the patient need not be in writing, nor does the alteration of a health care advance directive need to be in writing.[93]

The Act, furthermore, prescribes when a health care advance directive will be valid and find application.[94] The Act states that should there be any uncertainty regarding the withdrawal of a health care advance directive or the consistency of the health care advance directive being the patient's fixed decision, it will be deemed invalid.[95]

A health care advance directive will not find application in situations where the patient is able to give or refuse consent and has the mental capacity to do so.[96] Concern needs to be expressed at this point as mental capacity is not always possible to determine especially in an emergency setting. This might remain a point of contention when health care advance directives are involved, whether treatment was withheld or not.

The Act also states that a health care advance directive should be in writing, and should be signed by the patient and that the signature should be made in the presence of a witness, who should also sign the health care advance directive.[97] This brings into question the statement made in s24 that alteration or withdrawal of the health care

91 *Mental Capacity Act* 2005: sec 24(1).

92 2005: sec 24(3).

93 Sec 24(4-5).

94 Sec 25.

95 Sec 25(2).

96 Sec 25(3).

97 Sec 25(6).

advance directive need not be in writing. Thus, careful control exists at the creation of the health care advance directive; however, when changes are made or revocation of the health care advance directive takes place no such control exists. At this point it is proposed that changes to the health care advance directive or the revocation of the health care advance directive are important, even more important than the initial document, and that control over such changes should also exist in order to avoid abuse and misunderstanding.

The Act states the following:[98]

> "(2) A person does not incur liability for carrying out or continuing the treatment unless, at the time, he is satisfied that an advance directive exists which is valid and applicable to the treatment.
>
> "(3) A person does not incur liability for the consequences of withholding or withdrawing a treatment from the patient if, at the time, he reasonably believes that an advance decision exists which is valid and applicable to the treatment."

When considering these sections critically, the following points arise. Firstly, it provides the patient with the assurance that a health care practitioner could be held liable if s/he decides to continue treatment where a health care advance directive exists and it states not to do so.[99] Therefore, should a patient follow the prescribed requirements, they should have the peace of mind that they will not be forced to undergo certain treatments which they have expressly refused. Should it happen that these wishes are ignored, the health care practitioner could be held liable in terms of the Act.

Secondly, the health care practitioner is protected for withholding or withdrawing treatment, when s/he had reason to believe that there was a valid health care advance directive which had application to the treatment.[100]

When considering these two sections in the South African context, concerns come to mind. Both sections refer to a "person" and nowhere in the Act is a "person" described nor defined. In South Africa, this will allow for potential abuse, because the term "person" can include any person, whether medically trained or not. Also, to reasonably believe

98 Sec 26(2-3).

99 Sec 26(2).

100 Sec 26(3).

that a health care advance directive existed at the time of the withholding or withdrawing of treatment poses the possibility of abuse in South Africa because it can lead to health care practitioners not attending to a patient for other irrelevant reasons and base their actions or lack thereof on the reasonable belief that a health care advance directive existed. Therefore, it is proposed that proper identification of a health care advance directive and more specifically a DNAR order should be in place. The reason is that a DNAR order is, currently, a very vague term and no specified criteria have been set in order to determine whether the health care practitioner had reason to believe that the DNAR order was legitimate.

However, although the Mental Capacity Act does not make specific mention of DNAR orders, its description of a health care advance directive is comprehensive and could allow for a DNAR order. Refinement of DNAR orders should be compiled in the form of guidelines or amendments to the Act.

Guidelines do exist for England and Wales and will be discussed later in this Chapter.

4.2.2 Scotland

Different from England and Wales, Scotland does not have any legislation governing health care advance directives. The only form of legislation which might pass, is the code of practice which accompanies the Adults with Incapacity Act.[101] In this code of practice,[102] it is stated that when a competent person made his/her wishes known to a health care practitioner or any other relevant person, whether this was done in writing or verbally, it should be considered in circumstances where it might find application. A statement made which specifically refuses treatment is called a health care advance directive. The code of practice states that a health care advance directive could be potentially binding.

Thus, there is no legislation legally binding a practitioner to follow a health care advance directive or a DNAR order.

101 *Adults with Incapacity Act* 2000.

102 http://www.gov.scot/Publications/2010/10/20153801/2 (accessed on 3 October 2017).

The only form of guidelines is provided by the National Health Service (NHS) of Scotland. These guidelines will be discussed later in the chapter.

4.2.3 Northern Ireland

To date, Northern Ireland does not have any legislation governing health care advance directives nor DNAR orders.[103] Since no legislation prescribes the creation and enforcement of a health care advance directive, guidelines have been compiled in order to guide persons as to how they could make their wishes regarding specific medical treatments known.

The Mental Capacity Act 2016 of Northern Ireland acknowledges the right of a person to appoint another with power of attorney, in order to make decisions relating to health care on behalf of another.[104]

Furthermore, it is acknowledged that the authority given to another as power of attorney is subject to any health care advance directives made by the person.[105] However, the section regarding health care advance directives[106] is still on review and not yet effective.

Thus, of the four nations comprising the United Kingdom, England and Wales come the closest to having legislation governing DNAR orders, since their DNAR orders, could arguably be considered to form part of a health care advance directive or be an extension thereof. Scotland has only a code of practice from which some form of health care advance directives could be derived and Northern Ireland does not have any legislation governing health care advance directives nor DNAR orders, but they do have guidelines concerning DNAR orders.

Even though the United Kingdom does not have legislation specifically governing DNAR orders, as the USA does, South Africa could still consider what has been used and improve thereupon.

103 Sommerville 2013:91.

104 *Mental Capacity Act* 2016: sec 99.

105 2016: sec 99(2).

106 Sec 284.

4.3 GUIDELINES FOR DNAR ORDERS IN THE NATIONS OF THE UNITED KINGDOM

4.3.1 England and Wales

According to the guidelines used in England and Wales, a DNAR order is a document which is both issued and signed by a health care practitioner, in specific a physician. This DNAR order serves as a document to inform a medical team not to attempt or initiate CPR should the patient be in cardiac arrest. The DNAR order is a document intending to be a clear, accessible and recognisable statement, in order to assist health care practitioners when decisions need to be made in the event of a cardiac arrest.[107]

In a document provided by the National Health Services, entitled the National End of Life Care Program, it is made very clear that a DNAR order only refers to heart and lung resuscitation and that it does not in any way limit the provision of other forms of treatment which may benefit a patient. Thus, it is not to stop other beneficial interventions other than CPR.[108]

A DNAR order is not a legally binding document for England and Wales.[109] It is merely a document in which a patient can communicate their wishes regarding the refusal of CPR, since all health care practitioners are trained to always initiate CPR in the event of a cardiac arrest, unless the patient expressed otherwise.

In order for a person to be given a DNAR order or to obtain a DNAR order, discussions should be held with the patient. This will typically be the case when a patient is terminally ill. [110]

It is suggested that the same DNAR order be used across the country. This will ensure that health care practitioners become accustomed to the document and it will avoid

107 http://www.lwdwtraining.uk/doulas/doula-members-area/resources-links/ (accessed on 23 September 2017).

108 http://www.lwdwtraining.uk/doulas/doula-members-area/resources-links/ (accessed on 23 September 2017).

109 https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/ (accessed on 23 September 2017). 5.

110 https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/ (accessed on 23 September 2017). 4.

confusion. It appears, however, that there is not a standard form in use and that the forms do vary.

A written DNAR order can be for a specific time, after which the form needs to be reissued should the patient still wish to have its effect, or the DNAR order can be written for an indefinite period of time.[111] This does not mean, however, that the patient is not allowed to revoke the DNAR order. Should a patient still be in all his/her mental capacity, the patient can revoke and destroy the DNAR order as they please – and as such giving effect to the ethical principle of respect for autonomy.

The code of practice accompanying the Mental Capacity Act suggests that health care advance directives include certain details of the patient; this can also be the basic requirements for a DNAR order, namely:[112]

- The name, date of birth, identification number and current address of the person whose DNAR order it is.
- The name and address as well as the contact details of the person's attending General Physician.
- The DNAR order should contain a standard statement that it should be used when the person lacks the capacity to give consent.
- A clear statement on which treatments are refused.
- The date the document was written, and if only valid for a certain period, the expiration date of the document.
- The signature of the person writing the document as well as a witness and the attending General Physician.

The above-mentioned are guidelines as to what should be present in a health care advance directive and could also be used in an DNAR order. However, there are no set guidelines for DNAR orders, nor are there any standard recognizable forms to use for

111 https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/ (accessed on 23 September 2017). 4-5.

112 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf (accessed on 4 October 2017). 164.

DNAR orders. It should be considered as priority to create set guidelines and even standard forms for DNAR orders to ensure that the health care practitioner as well as the patients have certainty as it appears that health care practitioners and patients in England and Wales face the same concerns as health care practitioners and patients in South Africa. The concern of the patient is that they will receive CPR because the DNAR order is not with them or is difficult to find in the pre-hospital setting. For the health care practitioner, it is the uncertainty of what will happen to them if proper documentation is not presented. However, it appears from the Act that if the health care practitioner reasonably believed that a legitimate DNAR order existed, s/he will not be held liable for withholding or withdrawing treatment.[113] This is a point of concern, since the possibility of a factual dispute on whether the belief was reasonable could arise, removing the focus from the main issue, which is the death of a patient due to the withholding or withdrawal of CPR based on a notion that a DNAR order existed. In the pre-hospital setting, there is no time to consider whether a document is legitimate or not, and a decision leading to forgo CPR should be one based on certainty, which should be easily obtainable. It should be reiterated that in South Africa very clear guidelines should be provided, leaving no room for misinterpretation for else it could lead to a slippery slope of abuse.

4.3.2 Scotland

Scotland, to date, has no legislation governing health care advance directives nor DNAR orders.[114],[115] The NHS Scotland, however, produced guidelines to follow when creating a DNAR order.

A protocol was developed to determine whether the need exists to discuss DNAR orders with a patient. This is not needed should a patient want to create a DNAR order out of his/her own accord. The protocol suggests that once it is determined that a patient has a clear possibility for a cardiac arrest, a DNAR order should be discussed with the patient. Furthermore, the health care practitioner should also consider the possible outcome of CPR for the patient, for should the outcome be that CPR would not be successful, then

113 *Mental Capacity Act* 2005: sec 26(3).

114 Sommerville 2013:91

115 https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/ (accessed on 23 September 2017). 17.

a DNAR order should be considered. It is emphasised that a mentally competent patient should be part of the discussion and decision of a DNAR order.[116]

It is important to note that a DNAR order does not refer to any treatment other than CPR. The guidelines also are clear on the fact that should a patient have the mental capacity to make a decision, his/her wishes should be honoured. At no point does a family member's wishes prioritize over the patient's wishes.

However, when a patient lacks the mental capacity to make a decision regarding a DNAR order, relatives could be consulted as to what the patient's wishes might have been. The relatives should not be felt burdened with the decision as to whether or not to forgo CPR, unless they are the appointed health care proxy for the patient.[117]

The NHS Scotland guidelines also provide for emergency medical services where it is suggested that the dispatched emergency health care practitioners should be informed of the existence of a DNAR order when dispatched. It is, however, difficult to obtain such information from the person utilising the emergency medical services. Furthermore, it is made quite clear that the presence or absence of a DNAR order should not prioritize over good clinical judgement in an emergency situation where CPR could benefit the patient as for instance choking, or being struck by lightning where mere defibrillation would put the heart back into rhythm.[118]

4.3.3 Northern Ireland

As with Scotland, Northern Ireland has no legislation governing health care advance directives nor DNAR orders. The Compassion in Dying organisation created guidelines and information regarding the rights of persons in Northern Ireland pertaining to DNAR orders.

116 http://www.sad.scot.nhs.uk/media/16039/dnacpr-framework-aug-2016.pdf (accessed on 3 October 2017).

117 http://www.sad.scot.nhs.uk/media/16039/dnacpr-framework-aug-2016.pdf (accessed 3 October 2017).

118 http://www.sad.scot.nhs.uk/media/16039/dnacpr-framework-aug-2016.pdf (accessed 3 October 2017).

Although there is no legislation in Northern Ireland to enforce or regulate a DNAR order, persons with the required mental capacity are still encouraged to create a statement with their wishes, especially regarding refusal of medical treatment.

Persons should, however, keep in mind that creating a health care advance directive or DNAR does not ensure that it is legally binding, since the DNAR order cannot be legally binding because no legislation exists to make DNAR orders legally binding. The health care practitioner's personal values and beliefs regarding core ethical principles and depending on which core ethical value the health care practitioner believes to be the most important will influence his/her decision whether to forgo CPR or not.

The United Kingdom recently had a few occurrences of patients or the families of patients complaining that DNAR orders were placed in the patient's file without discussing it with the patient or the family members. A few of these complaints ended up in court and in the researcher's opinion, it could be attributed to the lack of legislation and the use of only guidelines.[119]

4.4 COURT CASES RELATING TO DNAR ORDERS

4.4.1 Tracey

In 2014, an important court case regarding DNAR orders came before the Court of Appeal in England, the so-called *Tracey*[120] court case. The appellant claimed that the staff members of the health care facility placed a DNAR order without consulting her or her surrogate first. The claim was based on the fact that there was no adequate consultation with Mrs Tracey or members of her family. There was no notice given to her or a family member regarding the imposing of the notice of a DNAR order, nor was she given a second opinion. Furthermore, the DNAR policy was not made known to her or a family member nor does the health care facility have a clear DNAR policy. Mrs Tracey should have been part of the discussions relating to a DNAR order, or her family

119 http://www.irishnews.com/news/healthcarenews/2016/05/03/news/dying-patients-having-do-not-resuscitate-orders-imposed-without-families-consent-506606/ (accessed on 4 October 2017).

120 *R (Tracey) v Cambridge University Hospitals NHS Foundation Trusts & Others* [2014] EWCA Civ 822.

members should have been given information relating to DNAR orders and a second opinion should be offered.

The court found that there was a duty on the health care practitioner to consult and discuss with Mrs Tracey or a family member the option of a DNAR order.

4.4.2 Winspear v City Hospitals Sunderland NHS Foundation Trust

Following the *Tracey* court case, in 2015 the *Winspear v City Hospitals Sunderland NHS Foundation Trust*[121] case came before the High Court of Justice.

Ms Winspear acting in her personal capacity and on behalf of the estate of Carl Winspear, the deceased, who had cerebral palsy[122] prior to his death. Thus, it is important to note that Mr Winspear lacked mental capacity. Very much like the *Tracey* court case, a DNAR order was placed in the patient's file without consultation with Ms Winspear or any other family member. Mr Winspear did not die due to a cardiac arrest, but due to a bronchial-pneumonia illness.

According to the attending health care practitioner, Dr Swarbrick, the DNAR form was not completed and he had the intention to speak to the family before completing the form.

The Court found that there was nothing in the *Tracey* case to suggest that the concept of human dignity applies any less in the case of a patient without sufficient mental capacity.[123] The court further found that consultation prior to placing a DNAR order is required in both cases of capacity and absence of capacity. The lack of cardiac arrest before the DNAR order was removed does not rectify the situation; it is still considered as an interference of private life, and it is also a very important decision to be made regarding health care since it could possibly save a life or lead to the death of another.

The Court acknowledged that this matter took place before the landmark *Tracey* court case, which ruled that either the patient or family members should be included in discussions and decisions regarding DNAR orders. However, it should be reiterated that

121 *Winspear v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB).

122 Cerebral palsy is an umbrella term used to describe a number of disorders affecting one's ability to move. This is due to damage to the developing brain which occurred during pregnancy or shortly after birth.

123 *Winspear v City Hospitals Sunderland NHS Foundation Trust:* 45.

consultation is very much a major part of the treatment plan, especially when a DNAR order is considered.

The two mentioned court cases took place in 2014 and 2015 respectively. However, in 2011, the Care Quality Commission conducted inspections in 100 English health care facilities. Among other failings, it was highlighted that elderly patients and their family members were often excluded from discussions regarding resuscitation and that DNAR forms were routinely inserted into older patient's files on admission of the patient or the decisions were left with junior health care practitioners.[124]

It is acknowledged that a patient doubting their recovery could interfere with the patient's morale and even their recovery, but this should not hinder a health care practitioner from discussing a DNAR order first with the patient or family member before placing the form in the patient's file.[125]

On 2 May 2016, the Irish News published an article[126] relating to dying patients who have DNAR orders imposed on them without the families' consent. The Royal College of Physicians conducted an audit in 2015 in which it was found that one in five families are not informed of a health care facility's intention not to perform CPR on a patient.

It was once again reiterated in the article as well that health care practitioners have a legal duty as imposed by the court in the *Tracey* case to discuss DNAR orders with their patients and/or family members prior to the DNAR order being placed in the patient's file.

Following the *Tracey* ruling, the Resuscitation Council UK placed their guidelines on review and are currently awaiting response from the public and professionals.[127]

4.5 CONCLUSION

The United Kingdom as a whole does not have one specific piece of legislation regulating or enforcing DNAR orders. England, Wales and Scotland have some legislation

124 http://www.making-connections.co.uk/uploads/206ba14f9becf4d4f75bccc3a75323db08c702b2.pdf (accessed on 4 October 2017).

125 Sommerville 2013:31.

126 http://www.irishnews.com/news/healthcarenews/2016/05/03/news/dying-patients-having-do-not-resuscitate-orders-imposed-without-families-consent-506606/ (accessed on 4 October 2017).

127 https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/ (accessed on 4 October 2017).

governing health care advance directives, but it does not specifically extend to DNAR orders.

Guidelines are used throughout the United Kingdom relating to DNAR orders. This however appears to not be sufficient since it does not give the person creating the DNAR order the peace of mind that his/her wishes would be adhered to. Furthermore, the guidelines prescribe that written documentation should be made use of, which poses a challenge in the pre-hospital setting.

Focussing on the pre-hospital setting, there is no legislation or proper guidelines to guide emergency health care practitioners regarding DNAR orders. Thus, it would not be unjustified should an emergency health care practitioner decide to not adhere to a DNAR order and still initiate CPR, due to uncertainty of the legality of the document.

However, the United Kingdom is still one step ahead of South Africa since it at least legally acknowledges health care advance directives in three of its Nations, whereas South Africa still does not have any legislation concerning end of life decisions not to mention health care advance directives or DNAR orders.

South Africa could consider the approach of the United Kingdom when deciding to develop either guidelines or legislation pertaining to end of life decisions. A first step would be to identify what could be considered as good guidelines and what should be considered as areas from which lessons should be learnt and making the same errors should be avoided.

The number of court cases relating to DNAR orders placed in patient's files without the patient or their family members being a part of a discussion is an indication that without proper regulation, the use of DNAR orders do have the potential for abuse - which should be avoided at all costs in South Africa.

As previously mentioned and discussed in the following chapter, South Africa does have the need for the development of end of life decisions including health care advance directives and DNAR orders. A well-considered approach should be followed. Creating guidelines first, before legislation, might be a quicker and more conservative approach to end of life decisions, but it should be carefully considered, due to the fact that it holds the possibility of abuse if not clearly and carefully compiled. It may be best to rather use

and learn from the United Kingdom and adopt what can be used in South Africa and improve on what might be potentially abused.

5. SOUTH AFRICA AND HEALTH CARE ADVANCE DIRECTIVES

But in this world, nothing can be said to be certain, except death and taxes - Benjamin Franklin

5.1 INTRODUCTION

Carefully reconsider the same scenario as mentioned in chapter 1:

You are a trained and registered health care practitioner. You are called to the residence of a male of a high age. Upon arrival at his home you find him in a semi sitting position in his bed. His wife and son is also present. He complaints about chest pains and shortness of breath.

You initiate your treatment by taking his vital signs such as blood pressure, heart rate, respiration rate, blood glucose level and oxygen (O_2) saturation levels. While you are busy with your treatment he lets out a moan and collapses. You attach the pads of the electrocardiography (ECG) machine to check for a shockable rhythm and the ECG indicates that he is in cardiac arrest. Since this was a witnessed cardiac arrest you check for a shockable rhythm, you find that there is no shockable rhythm present and you place the patient on a firm surface to initiate the protocol for cardiac arrest, which is one man Cardio Pulmonary Resuscitation (CPR), since you are the only registered health care practitioner at the scene.

As soon as you initiate CPR the wife verbally informs you that the patient has a Do Not Attempt to Resuscitate order (DNAR). The son however indicates that he has no knowledge of such an order. You request a written document, but the wife informs you that she cannot find the document.

As a health care practitioner, you are faced with two options in the above-mentioned scenario.

The first being that you can continue with the treatment of one man CPR, which you have initiated, until the written document is found. Otherwise, until the patient has spontaneous return of circulation, meaning that the patient has a palpable heartbeat.

The second option is to terminate the initiated CPR and take the word of the wife that there is a written DNAR order somewhere in the house.

5.2 THE LEGAL POSITION OF DNAR ORDERS IN SOUTH AFRICA

South Africa does not have any legislation governing health care advance directives, which includes DNAR orders and other end of life decisions.

Active euthanasia was declared illegal by the Supreme Court of Appeal in the Stransham-Ford case.[128] However, passive euthanasia is allowed in certain circumstances. Passive euthanasia aims to avoid the prolongation of life by allowing the underlying illness to take its natural course without extraordinary measures initiated.[129]

DNAR orders are a form of passive euthanasia, focussing specifically on withholding CPR. A DNAR order only indicates the withholding of CPR - not any other treatment, including comfort treatment.[130]

In South Africa, a DNAR order can be issued when the patient specifically refuses CPR with the requirement that the patient should have the mental capacity to refuse the treatment. Furthermore, when a healthcare practitioner has determined that CPR would be a futile attempt, a DNAR order can be issued. When a patient is unable to communicate his/her wishes, family members can be consulted and when an agreement is reached, a DNAR order can be issued.[131]

A DNAR order should be written by the attending health care practitioner, specifically a physician.

Although there is no legislation recognising health care advance directives or DNAR orders, it would appear as if the HPCSA implicitly recognises health care advance directives when they encourage patients to record their wishes regarding future treatment.[132] This, however, is no concrete acknowledgement of health care advance

128 *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* (531/2015) [2016] ZASCA.

129 McQuoid Mason 2013:223.

130 McQuoid Mason 2013:224.

131 McQuoid Mason 2013:224.

132 HPCSA Guidelines for the withholding and withdrawing of treatment 2016:2.

directives and the patient still has to rely, in good faith, on the health care practitioner acknowledging and adhering to his/her DNAR order.

5.3 THE PATIENT'S RIGHT TO REFUSE MEDICAL TREATMENT

The Constitution grants the human right to bodily and psychological integrity,[133] along with this right is the ethical principle of patient autonomy, which can be considered to be one of the core ethical principles.[134] Bodily integrity and autonomy combined provides the ability for a mentally competent adult to refuse medical treatment. In South Africa, and internationally, this is a subject of frequent debate and no concrete guidelines or solutions to the debate have been found - which leaves the limitations of the human right and ethical principle unclear.[135]

The recent ruling concerning of the *Stransham-Ford* case shed new light and focus on the end of life decision debate and the patient's right to refuse medical treatment.[136]

Starting with the core ethical principle of patient autonomy, which according to the key Greek terms *auto* and *nomos*[137] means self-rule or govern, it gives effect to each and every person who possesses the mental capacity to make their own choices regarding their bodily and psychological integrity. The core ethical principle of autonomy is given effect by s12(2)(b) of our Constitution, where it is stated that a person has the right to bodily and phycological integrity, which, among others, includes the right to security in and control over their own body.[138]

To act independently of third parties and to act intentionally are both facets of the core ethical principle of patient autonomy. This simply means that a patient with the necessary mental capacity should be allowed to make his/her own decisions regarding their medical

133 1996: sec 12(2).

134 HPCSA General ethical guidelines for the healthcare professions 2016:2-3.

135 Nienaber and Bailey 2016:73.

136 Nienaber and Bailey 2016:73.

137 Childress and Beauchamp 2001:57.

138 Sec12(2)(b).

treatment, or refusal thereof. This decision should be made without undue interference from a health care practitioner or a family member or any other related person.[139]

Thus, for a health care practitioner to provide true patient autonomy to a patient with the necessary mental capacity would mean that the health care practitioner should respect and honour a patient's wishes regardless of the health care practitioner's personal beliefs or convictions.

The right to bodily and psychological integrity as provided in s12(2) of the Constitution directly gives effect to the core ethical principle of autonomy and consequent from this is the right to refuse medical treatment. The Constitution is known to set the foundational regulations and rights and from there further legislation is developed to give effect to the mentioned rights and regulations. This is also true for the right to bodily and psychological integrity as the National Health Act[140] focuses on informed consent and the importance, for health care practitioners, to gain informed consent from their patients before any medical treatment commences. S6(1)(d) clearly states that a health care user has the right to refuse medical treatment and the health care practitioner should explain the implications, risks and obligations of such refusal.

The Constitution states that everyone has the right to bodily and psychological integrity, which includes the right to security in and control over their body.[141] If one differentiates between security and control, the result is that extra rights can be derived from the two facets. To have security in one's body indicates that a person should be free from fear of disturbance to bodily integrity. In a health care context, this means that a patient should be free from forced medical treatments which s/he did not give consent to or as some patients would wish to do, gave explicit orders like a DNAR order not to receive certain medical treatments.[142] To have control over one's body means that a person should have the right to make autonomous and independent decisions regarding their own body, giving them the right to refuse certain treatments. To have control over one's body also

139 Nienaber and Bailey 2016:74.

140 *National Health Act* 61/2003.

141 1996: sec12(2)(b).

142 Nienaber and Bailey 2006:74.

allows for a person to create a DNAR order or any other health care advance directive which they might deem necessary.[143]

Although a patient has the right to bodily and psychological integrity and the core ethical principle of autonomy, it should be made clear that this only allows a patient to decide whether or not they would consent to treatment and medical procedures. This does not give the patient the right to decide which course of treatment would be best suited for his/her condition, since the patient is not the trained health care practitioner.[144]

5.4 THE HEALTH CARE PRACTITIONER'S LEGAL POSITION – CRIMINAL LAW

The South African criminal law sets out five specific requirements, namely legality, an act or conduct, compliance with definitional elements, unlawfulness and culpability, to be met to be found guilty of a crime.[145]

Firstly, legality indicates that one needs to firstly consider whether the act which was committed can be considered as a crime in South Africa. An act will only be considered a crime or illegal when it is recognised by South African law as a crime.[146]

Secondly, an act or conduct indicates that the person who committed the crime must have done the act. Conduct can take the form of both an act as well as an omission, meaning the failure to act.[147]

Thirdly, compliance with definitional elements, simply put, indicates that in order for the conduct to be considered a crime it must fit the crime. This means that the conduct should fit the way it is described by legislation.[148]

Fourthly, unlawfulness directs that the act should have been against the law, not only against a specific law, but the act should be against all laws in their entirety.[149] This

143 Currie and De Waal 2005:287.

144 Herring 2010:21.

145 Snyman 2014:32.

146 Snyman 2014:29.

147 Snyman 2014:30.

148 Snyman 2014:30.

149 Snyman 2014:31.

means that the act committed should not, in any way, be justifiable by any other law. Thus, the term “unlawful” can be replaced with the words “unjustified’ or “without justification”.[150]

Lastly, we have culpability. Culpability, also known as *mens rea*, indicates that a person should have the criminal capacity to commit a crime and the person should have the intention or negligent intention to commit the crime.[151]

Considering the scenario above, one should consider whether the health care practitioner should be found guilty of a crime should he or she decide to ignore the DNAR order and commence with one man CPR. Also, could the health care practitioner be found guilty of yet another crime for not commencing with one man CPR, when it is later revealed that there was no DNAR document?

The suggested sequence as to whether a person can be considered guilty of a crime is to firstly determine if there was a voluntary act or omission, then one needs to determine whether the conduct complied with the definitional elements of the crime. After the first two elements were considered, one needs to determine whether the conduct was unlawful and then if the conduct was culpable. Only when all these elements are met, then the accused can be considered liable.[152]

A health care practitioner who actively resuscitates a person with a DNAR order carries the risk that s/he might be accused of assault to a patient, since no voluntary or implied consent was given. In fact, there was an explicit wish not to be resuscitated.

For the health care practitioner to be found guilty of assault, all the required elements of a crime should be proven beyond reasonable doubt. For the health care practitioner to be found guilty of murder or culpable homicide, the same required elements should be proven beyond reasonable doubt.

150 Snyman 2014:31.

151 Snyman 2014:32.

152 Snyman 2014:35.

5.4.1 A conduct

Conduct may take the form of an act or an omission. Positive conduct is often referred to as *commissio* and a failure to act, *omissio*.[153] A conduct or more specifically an act refers specifically to the type of act as mentioned in the definition in each crime.

An act can both create the basis of liability or limit such liability. If the act did not take place, then there is no basis for the claim of liability. For the purposes of this study, it is not deemed necessary to discuss the second, which is to limit liability.

Focusing on *omissio,* the imperative form finds application, meaning where someone had to do something.

When there was a legal duty on a person to act in a positive manner, but they omitted to do so, the failure to act is punishable. Certain identified situations exist where there was a duty to act. Firstly, where a statute places a duty on someone to act positively.[154] And secondly, where a person stands in a protective relationship towards somebody else.[155]

5.4.2 Definitional elements of a crime

Definitional elements can be referred to so as to understand the concise description of the requirements set by the law for liability for the specific type of crime with which a person is charged, as opposed to other crimes.[156] In laymen's terms then, it simply means that the conduct of the act committed should fit the minimum requirements of the definition of the crime in order to qualify as crime.

The reason for the requirement of definitional elements is to ensure that the elements, as described by the act, are a fair reflection of what the law actually wants to prohibit by labelling a specific conduct as a crime.[157]

153 Snyman 2014:51.

154 Snyman 2014:59.

155 Snyman 2014:60.

156 Snyman 2014:71.

157 Snyman 2014:72.

The contents of definitional elements as it applies to this study can be described using murder. For murder, a causal link between the act and the result should exist.[158]

Apart from the objective requirement of definitional elements, one should also consider the subjective requirement of definitional elements. When a crime requires intention, the intention will be considered in a subjective manner as it cannot be determined using only an objective manner[159] because each person's intentions are motivated differently.

Furthermore, for an act to be considered a crime, it should not only comply with the definitional elements, it should also be unlawful, meaning there should be some wrongdoing.[160]

Although elements are generally considered in an objective manner, some crimes require the element of intention, which is to be considered subjectively.

Snyman summarises the rules of causation stating that, firstly, the person committing the crime has to be the factual and the legal cause of, for example, the death of another. Secondly, to determine factual cause, the *conditio sine qua non* principle is applied; should you think away the act of the person whom committed the act, does the result also disappear? Thirdly, to determine the legal cause, one should consider whether it is fair and reasonable to regard the person's actions the reason for the result.[161]

It is also important that there should be a causal link, a nexus, between the action of the person and the result. The person's act should be both the factual and legal cause of death, in order to be considered guilty.

Omission could also be linked to causation. When a person's failure to act led to a specific undesired result, it is important that there should have been a legal duty on the person to act positively.[162]

158 Snyman 2014:72.

159 Snyman 2014:75.

160 Snyman 2014:74.

161 Snyman 2014:79.

162 Snyman 2014:89.

5.4.3 Unlawfulness

An act committed should be unlawful in order to be considered a crime. The mere fact that an act complies with the definitional elements, does not constitute that the act was in fact unlawful.

Unlawfulness could imply a number of things. It could be an act which is not according to the *boni mores* of a community. It can also be an act which causes more harm than benefit to a person.[163] There exists occurrences where an act, although meeting the definitional elements, could be justified, making it a lawful act. There are set grounds for justification, such as necessity and obedience to orders, amongst a few others.

5.4.4 Culpability

Culpability requires that the person who committed the act should be blameworthy, according to law, for his/her unlawful conduct.[164]

Before one considers whether a person was culpable in his/her conduct, one should be convinced that the act committed was unlawful. One should also consider whether the culpability was in the form of intent, *dolus,* or negligence, *culpa*.[165]

Accompanying culpability is criminal capacity; the person should have the mental capability to commit a crime and appreciate that it was a crime.

In order to meet the requirement of culpability, one should also have the intention to commit the crime. Intention is determined using a subjective test. To meet the requirement of intention, two elements should be met, namely cognitive, intellectual, and conative, voluntative.

The cognitive element of intention suggests that the person should have had the knowledge of the act as well as why the act is considered unlawful, which is found in the definitional elements. The conative element of intention suggests that the person should have had the will to commit the certain act or to have willed the result of the act.[166]

163 Snyman 2014:98.

164 Snyman 2014:145.

165 Snyman 2014:148.

166 Snyman 2014:177.

Negligence finds application in the requirement of culpability. Negligence, simply put, means that the person did not apply the required standard of care,[167] meaning that the reasonable person would have foreseen and took the necessary care, in the specific circumstances. This is also known as the objective test, which is used to determine negligence.

5.5 SPECIFIC CRIMES

After identifying the general elements of a crime, in order to accuse a person of committing a crime, specific crimes, which might find application to the scenario mentioned above, can now be identified.

Each of these specific crimes have their own set of requirements along with the general elements of a crime. Each of these will be discussed and applied to the scenario found in the introduction.

5.5.1 Assault

Referring to the scenario, should a health care practitioner initiate CPR and the family member informs the health care practitioner that the patient has a DNAR order and the health care practitioner decides to continue with CPR, s/he could be accused of assault.

The crime, assault, will be discussed and applied to the situation in order to determine whether the health care practitioner could be found guilty of assault.

Assault as defined by Snyman states that:

> "Assault consists in any unlawful and intentional act or omission
>
> a. which results in another person's bodily integrity being directly or indirectly impaired, or
>
> b. which inspires a belief in another person that such impairment of his or her bodily integrity is immediately to take place."[168]

167 Snyman 2014:204.

168 Snyman 2014:447.

From the definition it is clear that assault comprises certain elements, namely:

i. Conduct, which results in another person's bodily integrity being impaired;

ii. Unlawfulness; and

iii. Intention.[169]

ii. Conduct

For a person's conduct to be considered a crime, it should meet the requirements of unlawful conduct. The understanding of assault it that it is force applied to another person's body.

Providing CPR to a patient constitutes the application of a force to the patient's body. This application of force is a direct application of force. This form of conduct can be identified as *commissio.*

iii. Unlawfulness

Unlawfulness specifies that there should be no grounds for justification as to why the health care practitioner did initiate CPR when he was told not to due to the presence of a DNAR order.

Unless the health care practitioner would argue that s/he has a legal duty to provide emergency medical care as imposed on all health care practitioners by the Constitution[170] as well as the National Health Act,[171] this would be inferior to the ethical principle of respect for patient autonomy.

Thus, the health care practitioner's conduct should be considered unlawful.

iv. Intention

The health care practitioner should have had the intent to apply force to the patient's body. This is known as *dolus directus*. The health care practitioner is aware of the

169 Snyman 2014:447.

170 Sec 27(3).

171 Sec 5.

patient's wishes not to be resuscitated, yet s/he is initiating CPR - which is a painful procedure.

Assault is classified as a crime against bodily integrity. The Constitution clearly states that everyone has the right to bodily and psychological integrity.[172] This right is applied to provide patients with the right of autonomy and burdens health care practitioners to respect a patient's autonomy, regardless of the health care practitioner's own beliefs or convictions regarding certain treatments.

Furthermore, a patient should provide consent before any treatment is initiated[173] and although the patient is unconscious, s/he could have measures in place to clearly refuse certain treatments such as CPR.

For a health care practitioner to initiate CPR when a patient has clearly indicated that they would not wish to be resuscitated, by means of a DNAR order, will constitute a criminal offence, namely assault.

5.5.2 Murder

Referring to the scenario, should a health care practitioner decide not to initiate CPR where there is doubt regarding the existence or the legitimacy of a DNAR order and the patient dies, the health care practitioner could be accused of murder.

The crime, murder, will be discussed and applied to the situation in order to determine whether the health care practitioner could be found guilty of murder.

Murder can be defined as:

> "The unlawful and intentional causing of the death of another human being."[174]

From the definition it is clear that murder comprises certain elements, namely:

i. Causing the death;

ii. Another person;

172 Sec 12(2)(b).

173 *National Health Act* 61/2003: sec 7.

174 Snyman 2014:437.

iii. Unlawfulness; and

iv. Intention.[175]

i. Causing the death

Causing the death of another person can be done either through a positive act, *comissio*, or the failure to act, *omissio.* It is important that the conduct be voluntary in order to constitute murder. The person should also be the factual and legal cause of the other's death.

Consider a health care practitioner who does not initiate CPR in the event of a cardiac arrest. The failure to initiate CPR constitutes *omissio* since the Constitution[176] and the National Health Act[177] provide that no one may be refused emergency medical care.

ii. Another person

One person's conduct should lead to the death of another human being. The human being should be alive at the time of the conduct.

Following this scenario, however, a person suffering from a cardiac arrest is considered clinically dead. A distinction is made between biological death and clinical death. Clinical death occurs when the heart stops "pumping" blood and breathing stops. This will be the instances where health care practitioners would still initiate CPR. Once the brain has been deprived of oxygen for more than 4-6 minutes, permanent brain damage occurs, which leads to irreversible death - also known as biological death.[178]

Thus, a health care practitioner would be unable to rely on the argument that the patient was already dead, and s/he did not cause the patient's death by not initiating CPR.

iii. Unlawfully

The conduct must be unlawful. In the case of murder, there would be no grounds for justification for not initiating CPR. When a patient is in need of CPR and a health care

175 Snyman 2014:437.

176 Sec 27(3).

177 Sec 5.

178 https://infolific.com/health-and-fitness/first-aid/clinical-death-biological-death/ (accessed on 25 October 2017).

practitioner does not initiate the CPR due to the possibility of a DNAR order, it will constitute unlawful conduct.

iv. Intentionally

Intention consists of the elements cognitive and conative. The health care practitioner would meet the requirements of both elements since s/he knows that not initiating CPR would lead to the biological death of the patient. This is unlawful where a patient is still clinically dead and has not expressed a refusal of CPR. Thus, the cognitive element has been fulfilled.

As a health care practitioner would know that not initiating CPR would lead to the biological death of a person, the health care practitioner should have the will to let this be the result of not initiating CPR.

When a health care practitioner does not initiate CPR on a clinically dead patient where there is no legitimate indication of a DNAR order, it constitutes murder, since it will lead to the biological death of the patient. The health care practitioner can be charged with murder.

5.6 LAW OF DELICT

The South African law of delict sets out five principles, namely conduct, wrongfulness, fault, causation and damage to be met to be found liable of a delict.[179]

Firstly, for a person to be liable in terms of the law of delict, the wrongdoer should have caused damage or harm to another person, by means of an act or conduct.[180]

Secondly, the act or conduct which caused damages to another person should have been a wrongful act.[181]

179 Neethling and Potgieter 2015.

180 Neethling and Potgieter 2015:25.

181 Neethling and Potgieter 2015:33.

Thirdly, as with criminal law, the wrongdoer should be at fault, meaning the wrongdoer should be blameworthy.[182]

Fourthly, causation implies that there should be a nexus or a causal link between the conduct and the damage.[183]

And lastly, damage had to occur, due to the wrongful conduct.[184]

Considering the scenario above, one should consider whether the health care practitioner should be found liable in terms of a delict should he or she decide to ignore the DNAR order and commence with one man CPR.

5.6.1 Conduct

For a delict to be constituted, the conduct should have been human conduct and voluntary.[185]

Thus, a health care practitioner providing CPR where there is a DNAR order is acting voluntary, since no one is forcing him/her to initiate CPR and the act is an act of *commissio.*

5.6.2 Wrongfulness

After establishing that a person committed and act, the wrongfulness of the act has to be determined. In order to do this, it has to be established that a legally recognised interest was infringed upon and whether the infringement is legally unacceptable. The latter is determined by the *boni mores* of the community.[186]

A special relationship between parties, such as a patient and a health care practitioner, places certain responsibilities on the parties - which if not followed, could lead to delictual claims. In the case of *Steward v Botha*[187] the parents of a very deformed child brought a delictual claim against the health care practitioner attending to the mother during her

182 Neethling and Potgieter 2015:129.

183 Neethling and Potgieter 2015:183.

184 Neethling and Potgieter 2015:221.

185 Neethling and Potgieter 2015:25.

186 Neethling and Potgieter 2015:34.

187 *Steward v Botha* 2008 6 SA 310 (SCA).

pregnancy. They alleged that a failure from the doctor to disclose that the foetus was deformed kept them from terminating the pregnancy and as a result the child was born with deformities and requiring special care. The claim was brought on the so-called "wrongful life". The court held that the claim for wrongful life did not disclose a cause of action.

Neethling and Potgieter are of the opinion that the health care practitioner who negligently causes a child to be born with deformities, due to the health care practitioner not informing the parents of the deformities while in utero, should be regarded as a wrongful act on the part of the health care practitioner.[188]

Consider the health care practitioner who initiates CPR while a DNAR order is present. The patient might be suffering from a terminal illness and due to the possibility of an imminent cardiac arrest, the patient had decided to obtain a DNAR order. By initiating CPR on a patient suffering from a terminal illness would only cause the patient to suffer longer, should the health care practitioner have return of spontaneous circulation, after attempting CPR. When considering the opinions of Neethling and Potgieter, the health care practitioner did act in a wrongful manner by initiating CPR. Furthermore, the patient also has the right to bodily and psychological integrity[189] and not to be subjected to treatment without his/her consent.[190] Thus, if specifically indicated that the patient do not wish to receive CPR by having a DNAR order in place, the health care practitioner should respect the patient's wishes.

The court, however, did find that there was no cause of action for the claim of wrongful life in *Steward v Botha.*

5.6.3 Fault

Fault, as with criminal law, appears in two forms; namely, intentional, *dolus*, and negligence, *culpa.* To constitute a delict, fault needs to be proven.

188 Neethling and Potgieter 2015:70.

189 *The Constitution of the Republic of South Africa*: sec 12(2).

190 *National Health Act* 63/2003: sec 7.

The person suspected of the delict should have the mental capacity to understand that the act committed was wrong. Furthermore, the wrongdoer should also have the intent towards a certain result and the knowledge that it is wrongful.[191]

A health care practitioner is trained in the knowledge that a patient's consent should always be obtained before treatment can commence. Should it not be possible to obtain consent, implied consent could be assumed, unless that patient clearly indicates the refusal of certain treatments through a DNAR.

Furthermore, a trained health care practitioner is considered a person with the necessary mental capacity, for in order to register as a practitioner, one has to have a physician's approval that one is fit to practice, physically and mentally. Also, the trained health care practitioner must be aware that initiating CPR with the knowledge of a DNAR is a wrongful act.

5.6.4 Causation

The wrongdoer should cause damage in order to constitute damage; furthermore, there should be a causal link between the wrongdoer's actions and the damage caused.

Similarly to criminal law, the *condition sine qua non* theory is mostly used to determine whether there is a causal link between the action and the damage. The theory suggests that if the action is thought away, the result should also disappear in order for someone to be found guilty of this element. If the result does not disappear, it could indicate that the wrongdoer's conduct did not cause the damage.

A health care practitioner initiating CPR when a patient is clinically dead, aims to reverse clinical death by restarting the patient's heart. Should the health care practitioner not be successful, biological death would result. However, should the health care practitioner achieve the aimed result, being the return of spontaneous circulation, the patient would be hospitalised and cared for until s/he can be discharged or relapses or dies.

When a patient suffers from a terminal illness and make their wishes known through a DNAR order, they are motivated by a number of reasons to do so. A few being that they do not wish to be resuscitated when cardiac arrest is imminent. Furthermore, palliative

191 Neethling and Potgieter 2015:133.

care for terminally ill patients are costly; some patients return home with the intent to die at home surrounded by their loved ones and receiving CPR would place the patient back in an unfamiliar facility away from the comfort of their own home and loved ones.

Receiving CPR when the patient has made their wishes known through a DNAR order, does cause damages. There is also a clear link between the health care practitioner's initiation of CPR and the patient's return of spontaneous circulation and their hospitalization. Thus, causation can be determined.

5.6.5 Damage

To be compensated, one needs to prove that damage or loss was suffered. Thus, in order to constitute a delict, damage needs to be proven.

The law of delict provides for compensation for damage and satisfaction. The first intends to place a monetary value on the loss and the latter aims to repair the damage caused to personality.[192]

Patrimonial loss has a direct impact on a person's patrimony, a person's positive assets.[193] When a person is forced to live longer, due to CPR being initiated when they were in cardiac arrest, one could argue that this creates an increase in their debt, since the emergency service provider as well as the health care facility has to be paid. In contrast, if the health care practitioner did not initiate CPR, as per DNAR order, the patient would have died and expenses stopped.

However, determining the amount of loss would be difficult and unlike the USA and UK, South Africa does not have tort law, where specific amounts are set out for specific damages; thus, the wronged person would have a difficult burden to prove damage and the amount of damage.

Considering the principles as set out above, it would arguably be unlikely that a health care practitioner would be found liable for a delict when initiating CPR where there is a DNAR order. As mentioned in Chapter 3, there is yet to be a successful claim of the

192 Neethling and Potgieter 2015:221.

193 Neethling and Potgieter 2015:229.

"wrongful prolongation of life". Claims have been brought to courts in the USA, none of which has been successful thus far.

One last aspect to consider is that for a delict, the burden of proof is a balance of probabilities. Thus, different from criminal law, liability does not have to be proven beyond reasonable doubt, which gives a bit of leeway. It is, however, important to note that this does not ensure that health care practitioners will not be accused of a delict in future when not adhering to a DNAR order which will the provide a precedent.

5.7 END OF LIFE DECISION CASE LAW

South Africa does not have specific legislation governing health care advance directives nor DNAR orders. However, there has been a few rulings, giving guidance and precedence on health care advance directives.

5.7.1 Clarke v Hurst[194]

The court case of *Clarke v Hurst* is considered as one of the *locus classicus* regarding health care advance directives and end of life decisions.

Dr Clarke, the patient, was undergoing a medical procedure and during this procedure a sudden drop in his blood pressure occurred, causing his body to go into cardiac arrest. Cardiopulmonary resuscitation was initiated, but due to the depravation of oxygen to the brain, he suffered irreversible brain damage - leaving him in a permanent vegetative state with no prospect of improvement in his condition and no possibility of recovery. The patient was initially placed on a ventilator, but weaned off, thus breathing on his own, but fed through a naso-gastric[195] tube.

The applicant to the court, the patient's wife, applied to be appointed as curatrix to the patient's person. This would provide her with powers, in the capacity as curtarix, to agree to or withhold any medical interventions or procedures for the patient and to authorise the discontinuance of any current medical treatment that the patient was receiving.[196]

194 *Clarke v Hurst NO and Others* [1992] 4 All SA 763 (D).

195 Through the nasal canal into the stomach.

196 *Clare v Hurst NO and Others*: 764.

The patient was a member of the South African Voluntary Euthanasia Society and he signed a 'Living Will', which clearly stated that if there was no reasonable expectation of his recovery from extreme physical and/or mental disability, it is his desire that he be allowed to die and not be kept alive by artificial means and heroic measures.[197]

During his active life, the patient held strong views regarding the right to die with dignity. In a speech delivered by him, he said:

> 'I feel sure that the general public gets a certain degree of satisfaction in knowing that if they, by a stroke of misfortune, become cabbages or suffer prolonged and intractable pain where a successful outcome is impossible, no valiant and fruitless endeavours will be instituted by the medical team to prolong intense suffering and anguish and to, in fact, prolong death.[198]

The court found that an adult of full legal competence has, while *compos mentis*, the right to security and integrity over their own body. Should the person, while exercising this right, decide not to undergo certain medical interventions or procedures, whether the decision would lead to his/her death, s/he is fully entitled to do so.[199]

The court referred to *Esterhuizen v Administrator*[200] where it was also found that should a person be of a sound mind, *compos mentis*, s/he should be allowed to direct health care practitioners and other medical staff to be allowed to die should s/he lapse into a persistent vegetative state with no prospect of recovery.

According to judge Thirion, the *boni mores* of society was the key factor to consider regarding whether allowing the discontinuance of artificial nutrition of a patient with the result of death would be wrongful. The consideration would be whether society finds the discontinuance reasonable.[201]

Advances in research and medicine have made it possible for patients to receive cardiopulmonary resuscitation in the event of a cardiac arrest. The result of this is that patients may be resuscitated and kept alive when there is not the slightest possibility that they would ever again be able to consciously experience life. When the supply of oxygen

197 *Clare v Hurst NO and Others*: 765.

198 *Clare v Hurst NO and Others*: 765.

199 *Clare v Hurst NO and Others*: 769.

200 *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T).

201 *Clare v Hurst NO and Others*: 787.

has been cut off to the brain, it is a matter of minutes until the brain cells start dying off. Thus, resuscitation poses a considerable possibility that by the time the patient has been resuscitated and has some return of spontaneous circulation, the brain may be all but destroyed and the autonomic nervous system and brain stem may nevertheless be able to keep the body biologically alive, but the patient will not regain consciousness while being in this autonomous state. And it is in these instances where health care practitioners would need do decide to remove all life sustaining treatment from the patient.[202]

The court found that the applicant was acting in the best interests of the patient seeking to discontinue all life sustaining treatments. The applicant was appointed as curatrix with the powers to agree to or withhold any medical interventions or procedures and also to authorise the discontinuance of all life sustaining treatment, without regarding the act as wrongful or unlawful.[203]

Considering the case of *Clark v Hurst,* the first observation would be that should Dr Clarke have had a DNAR order, he would never have been placed in a permanent vegetative state, since CPR would not have been initiated.

Furthermore, he was well known for his association with societies such as the South African Voluntary Euthanasia Society, and his views on end of life decisions was no secret.

Dr Clarke underwent the medical procedure in 1988, and it was already during this time that members of society were advocating for the right to die with dignity. This court case has set a precedence allowing the removal of all life sustaining treatment, also known as passive euthanasia. It has been almost 30 years since this incident, which is not a very rare one, and no progress has been made regarding guidelines or legislation allowing for end of life decisions.

202 *Clare v Hurst NO and Others*: 787-788.

203 *Clare v Hurst NO and Others*: 789.

5.7.2 Castell v De Greef[204]

The court case of *Castell v De Greef*, although more focussed on medical negligence, has some key findings which can be used to strengthen the argument for patient autonomy in particular.

Firstly, it was found, by judge Ackermann, that it is for the patient to decide whether or not s/he would like to undergo certain medical interventions or procedures; this freedom of choice gives effect to a person's fundamental right to self-determination. Whether the patient's attitude is grossly unreasonable is irrelevant. The right to bodily integrity and patient autonomy entitles the patient to refuse medical treatment.[205]

Secondly, the court laid down certain requirements to be met should a health care practitioner wish to use a claim that a patient consented to the procedure and therefore the health care practitioner cannot be held liable. The patient consenting to the medical intervention or procedure should have knowledge of the nature of the intervention or procedure and also be aware of the harm or the risk; they should also be able to understand and appreciate the associated harm or risk and what the intervention or procedure entails. The patient consenting to the medical intervention or procedure should also consent to the harm or assume the risk relating to the intervention or procedure and the consent given should be to all the consequences of the intervention or procedure.[206]

Thus, from the *Castell v De Greef* case one can firstly identify the importance of the right to bodily integrity and the ethical principle of respect for patient autonomy. Thus, a patient should be granted the opportunity to form a health care advance directive and specifically a DNAR order should s/he wish to do so.

Secondly, one can also establish that should a patient create a DNAR order and upon consenting to this documentation the patient was *compos mentis* and had knowledge of the extent of such a document and was able to understand and appreciate what the consequences of such a DNAR order would be, the health care practitioner cannot be held liable for adhering to the written DNAR order.

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204 *Castell v De Greef* 1994 (4) SA 408 (C).

205 *Castell v De Greef*: 409.

206 *Castell v De Greef*:409.

5.7.3 Stransham-Ford[207]

The applicant, a terminally ill person, sought permission from the High Court to have a health care practitioner assist him in dying. The applicant died, due to natural causes, while the order granting the application was given.

In the Supreme Court of Appeal, the court acknowledged the fact the law has become part of a debate regarding life and death. This is the result of advances made by modern medicine in the ability to prolong life and postpone death. This has caused us to rethink and redefine the concept of death. Although advances in medicine is largely welcomed, it also has the effect that it can lead to the process of dying being protracted, painful and burdensome.[208]

Judge Wallis further also found that a person may refuse medical treatment, which might have prolonged life. The right to refuse medical treatment is an aspect of personal autonomy, which is protected by the Constitution. When a patient is treated without the proper obtainment of his/her consent, the treatment would be regarded as an assault.[209]

In *Re Conroy*[210] it was found that refusing a medical intervention or procedure allows for the disease to take its natural course; if death is the result of such a refusal, it would be the primarily result of the disease and not the result of a self-inflicted injury.

This applies to invasive surgery, the administration of drugs or therapies and the use of machines for the purpose of medical interventions or procedures. It was found by the Supreme Court of Appeal that the refusal of such medical interventions or procedures gives effect to the Constitutional human right of dignity[211] and bodily integrity.[212] The only

207 *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* (531/2015) [2016] ZASCA 197.

208 *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others*:3(1).

209 *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others*:22(31).

210 *Re Conroy* 486 A.2d 1209 (N.J.S.C. 1985) at 1224.

211 Sec 10.

212 Sec 12(2)(b).

requirement is that the person making the decision, whether it is in advance or at the time, should be *compos mentis.*[213]

Should a patient be of a sound mind and refuse medical interventions or procedures, a health care practitioner will not commit a criminal offence when ceasing such medical treatments. A health care practitioner should make such decisions in conjunction with the family or other persons having responsibility for the patient. Should there be uncertainty or differences regarding the approach, the courts may be approached for an order.[214]

An appeal was brought against the order of the High Court and the Supreme Court of Appeal upheld the appeal, thus not allowing a health care practitioner to assist a patient in dying by providing or administering a lethal drug.

The Supreme Court of Appeal also found that this was not an appropriate case to develop South African law since the deceased's cause of action ceased when he died. It should be noted that this is a very positivistic approach to the matter and it would almost appear as if the courts are simply reluctant to address the issue of end of life decisions and would rather opt to find reasons to keep it at bay instead of approaching the matter.

5.7.4 ES v AC[215]

The court case of *ES v AC* was brought to the Namibian Supreme Court of Appeal. South Africa does not have any legislation to enforce or regulate the use of health care advance directives, specifically DNAR orders. S8(3)(b) of the Constitution of the Republic of South Africa provides that when a provision of the Bill of Right is applied to a natural or juristic person, a court may in order to give effect to a right in the Bill, apply, or if necessary, develop the common law to the extent where legislation does not give effect to that right. Thus, as the case of *ES v AC* focusses primarily on patient autonomy, it should be considered when developing South African common law.

213 *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others*:23(32).

214 *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others*:25(33).

215 *ES v AC* (SA 57/2012) [2015] NASC 11.

It should also be noted that in the case of *ES v AC,* judge O'Reagan, a South African judge, was the concurring judge along with judge Shivute.

Mrs ES, the appellant, is a 38-year-old woman. She is a mother of three children, and this court case relates to the birth of the third child and what transpired after the birth. Mrs ES is a Jehovah's Witness and according to the belief of their specific moral and religious code, there is a scriptural command to abstain from the ingestion of blood.

It should be noted that Mrs ES has been a devoted Jehovah's Witness for more than 20 years and she held firmly to her beliefs.

In this matter, Mrs ES appeals against the orders made by the High court, which was to appoint her brother MR AC as curator to Mrs EC in order to allow him to authorise medical procedures such as blood transfusions, should it become necessary.

After the birth of her third child, which was done by caesarean section, it became apparent that a hysterectomy was needed to control the bleeding. During the procedure to perform the hysterectomy, Mrs ES had a major haemorrhage causing her to lose a substantial amount of blood, so much so that a blood transfusion was almost needed. Mrs ES, while in the maternity ward, still refused to have a blood transfusion.

During the appeal, the court had to decide, among other things, whether the rights of a person, who has young children, are submissive to the rights of the children; in other words, that the individual's right to refuse a blood transfusion in a life-threatening situation should not supersede the children's right to be raised by both parents.[216]

In the case brought to the High Court, it was argued that Mrs ES's right to freedom of individual autonomy should be considered against the rights of Mrs ES's newborn child, her other two children, and in the interest of her wider family and society in general.

The court of appeal's view was that it had a substantial interest in matters that concerned constitutional questions relating to an individual's rights. In the court's view, the right to

216 *ES v AC* 2(4).

bodily autonomy, the right to freely practice one's religion and the freedom from discrimination were involved.[217]

The Namibian Constitution affords an individual the right to protection of liberty[218] as well as the right to respect for human dignity.[219] These two rights give direct effect to the ethical principle of patient autonomy. The principle of patient autonomy affords a person the basic human right to be asserted control over his/her own body. This will also entail that a person may choose to forgo certain medical procedures and treatments and this choice should be respected for as long as the person is *compos mentis.*

The Supreme Court of Namibia referred to the case of *Castell v De Greef*[220] where it was stated that:

> 'It is clearly for the patient, in the exercise of his/her fundamental right to self-determination, to decide whether s/he wishes to undergo an operation, and it is in principle whole irrelevant that the patient's attitude is grossly unreasonable in the eyes of the medical profession: the patient's right to bodily integrity and autonomous moral agency entitles him/her to refuse medical treatment.'

It should also be mentioned that the Royal College of Surgeons in England has a very high regard for the command to abstain from the ingestion of blood by the Jehovah's Witnesses; it is referred to as a 'deeply held core value to regard a non-consensual transfusion of blood as a gross physical violation'.[221]

The Supreme Court of Namibia also referred to an unpublished doctoral thesis by Van Oosten, entitled: 'The Doctrine of Informed Consent in Medical Law' stating that:

> "The fundamental principle of self-determination puts the decision to undergo or refuse a medical intervention squarely where it belongs, namely with the patient. It is, after all, the patient's life or health that is at stake and important though his life and health as such may be, only the patient is in the position to determine where they rank in his order of priorities, in which the medical factor is but one of a number of considerations that influence his decision

217 *ES v AC* 6(38-39).

218 *The Constitution of the Republic of Namibia*: sec 7.

219 Sec 8.

220 *Castel v De Greef* 1994 (4) SA 408.

221 https://www.rcseng.ac.uk/library-and-publications/college-. publications/docs/code-of-practice-for-the-surgical-management-of-jehovahs-witnes/sees (accessed on 24 September 2017).

> whether or not to submit to the proposed intervention. But even where medical considerations are the only ones that come into play, the cardinal principle of self-determination still demand that the ultimate and informed decision to undergo or refuse the proposed intervention should be that of the patient and not that of the doctor."

In jurisdictions such as Canada and the United Kingdom, courts have accepted the common-law validity of a health care advance directive. These documents are described as written documents in which an adult patient makes provision for health care decisions, either by appointing another person to make decisions on the patient's behalf, knowing what the patient's wishes would have been, or by thoroughly indicating what treatment they are willing to undergo or would like to refuse.

The Mental Capacity Act[222] of the United Kingdom allows for a person to be granted lasting powers of attorney[223] as well as the creation of a health care advance directive.[224]

In *ES v AC,*[225] Mrs ES appointed her husband MR S as her designated health care agent, who also shared her belief as a Jehovah's Witness. Although no legislation has been passed in Namibia giving legal effect to a health care advance directive or durable power of attorney, it is Judge Shivute's opinion that when a health care advance directive is written and contains specific directions and is not compromised by undue influence, it should constitute clear evidence of a patient's wishes regarding medical procedures and interventions.

The court also considered the interest of the children, which in the researcher's view should not be a contributing factor as to whether a patient should have the right to patient autonomy, since it infringes on the right of no discrimination, and although not listed, this would be on the grounds of the patient being a parent, which for one does not diminish a person's mental capacity; hence, they should be allowed to make their own decisions based on their beliefs and/or values.

The Namibian Supreme Court of Appeal supported the conclusion that the interest of the children should not outweigh the parent's right to autonomy allowing the parents to make

222 *Mental Capacity Act* 2005.

223 Sec 22-23.

224 Sec 24.

225 *ES v* AC 2(8).

decisions regarding medical treatment that affect the parents themselves. This was supported, by among others, the finding of the court in England and Wales which reaffirmed the right of a pregnant women to refuse medical treatment even if it may imperil the life of her unborn child.

In Lady Justice Butler-Sloss the court of Appeal in *Re v MB,*[226] it was found that:

> 'A competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death.'

The Namibian Supreme Court of Appeal felt very strongly that the right to choose which medical interventions would be consented to and which medical interventions would be refused was an absolute human right. This reveals willingness to protect a person's liberty, self-determination and dignity, especially where medical interventions and procedures to the person's own body is concerned. The ethical principle of patient autonomy should be the overriding principle since it promotes the rights to liberty, privacy and health.[227]

The ethical principle of respect for patient autonomy is of central importance to the protection and promotion of human dignity and liberty in any free and open democracy. To deny an individual the freedom of choice regarding his/her own health can only lessen, and not enhance, the value of life.[228]

The Namibian Supreme Court of Appeal granted the appellant her appeal to remove Mr AC as the curator and the High Court order directing the treating doctor to render appropriate medical interventions and procedures.

5.8 END OF LIFE DECISIONS BILL

In 1998, the South African Law Commission submitted a project called Project 86, which mainly focussed on euthanasia and the artificial preservation of life. The End of Life Decisions Act 1999 was the proposed bill from the report.

226 *Re v MV (An Adult: Medical Treatment)* [1997] 2 FLR 426:60.

227 *ES v AC* 11(71-72).

228 *ES v AC* 12(72-73.)

The Bill mainly focussed on legalizing active euthanasia and the regulatory circumstances surrounding the legalization of active euthanasia.

The Bill also recognised the right to refuse medical treatments and to a lesser extent, health care advance directives.

Along with the Project, Annexure C contained a proposed Bill wherein it acknowledged that a mentally competent person may refuse medical treatment. It is stated that should it appear to the health care practitioner that the patient is refusing treatment, and that this refusal is based on a free and considered exercise of his/her free will, the health care practitioner should give effect to the decisions or refusals, made by such a competent person, even though the refusal may lead to the death of the patient.[229]

The Bill also made provision for directives as to the treatment of a terminally ill person, hence health care advance directives. It is stated that a person over the age of 18 years and of a sound mind will be able to issue a written health care advance directive as to indicate what care s/he would like to refuse when diagnosed with a terminal illness. This power of person to refuse treatment could also be transferred to another through written power of attorney. The written health care advance directive would be a good guideline for the person with power of attorney to know the patient's wishes.[230]

Furthermore, the Bill also made provisions as to the conduct in compliance with health care advance directives or on behalf of a terminally ill person. It is stated that a health care practitioner has the power to decide whether it would be just to give effect to the refusal of medical care, where it will hasten the death of the patient.[231] Should a health care practitioner give effect to the refusal of treatment, it should be properly recorded as to the reasons why the health care practitioner did not provide treatment.[232]

229 *End of Life Decisions Act* 1999: sec 3(2).

230 1999: sec 6(1-2).

231 Sec 7(1-3).

232 Sec 7(5).

Should a health care practitioner give effect to the refusal of treatment and the health care advance directive or power of attorney was in order and legitimate, then the health care practitioner did not act unlawfully, even if the refusal lead to the patient's death.[233]

If there is any concern regarding the authenticity of a health care advance directive, the health care practitioner is advised to continue with treatment, even if the health care advance directive indicates a refusal of such treatment.[234]

When the Report was handed to the Minister, it was deemed of lower priority and that it only favoured the rich.[235] It was only brought up again in the *Stransham-Ford* case, but ever since no further mention was made of it again, and it would appear as if all matters relating to end of life decisions are preferred to be handled on a case to case basis. This in the researcher's view, now definitely, only caters for the rich as a court case and counsel is expensive. This is also impractical for refusal of treatments such as CPR, since there is simply not enough time to have a judge decide whether CPR can be withheld.

5.9 THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA AND THE PROFESSIONAL BOARD OF EMERGENCY CARE

The Health Professions Council of South Africa (HPCSA) was established by the Minister of Health through the powers provided to him in the Health Professions Act.[236] One of the key objectives of the HPCSA is to promote and regulate the relationships between registered health care practitioners and the interest of the public.[237]

The Health Professions Act also allow for the Minister, at the recommendation of the HPCSA, to establish a professional board for a specific profession, which in the case of emergency medical care is the Professional Board of Emergency Care (PBEC).[238]

233 Sec 7(6).

234 Sec 7(4).

235 http://hsf.org.za/resource-centre/hsf-briefs/end-of-life-decisions-in-south-africa-part-1-life-is-dependent-on-the-will-of-others-death-on-ours (accessed on 8 October 2017).

236 *Health Professions Act* 56/1974: sec 2(1).

237 56/1974: sec 3(b).

238 Sec 15.

With this, some of the key objectives of a professional board are to maintain and enhance the dignity of the profession and the integrity of the registered persons practicing the profession and while doing so to guide the profession and protect the public.[239] In order to reach these objectives, certain powers have been provided to the PBEC, which include the removal of a name from the register or to suspend a registered person from practicing his/her profession while a formal inquiry has been instituted.[240]

The PBEC has the power to institute and inquiry into charges of misconduct and should the health care practitioner be found guilty by the professional board of such conduct, the professional board can impose any fitting penalties. If the complaint, charge or allegation is likely to form part of a criminal case in a South African court of law, the professional board may postpone the inquiry until the court has made a ruling.[241]

Should a registered health care practitioner be found guilty of improper or disgraceful conduct, the health care practitioner could, among others, be suspended for a specific period or have his/her name removed from the register and be unable to practice any further.[242]

Thus, considering the above, it is clear that a registered health care practitioner must adhere to rules and guidelines as set out by the HPCSA and the PBEC and if the health care practitioner does not adhere to such rules and guidelines, an inquiry could be instituted.

As a result, should a health care practitioner, for instance, ignore a DNAR order and be charged with a criminal offence of assault, s/he also can be expecting an inquiry from the PBEC, with the risk of being suspended or removed from the register, should s/he be found guilty of misconduct.

Health care practitioners should also be protected from inquiry by the PBEC for adhering to a patients DNAR order. Since it is not recognized by any legislation, the health care practitioner could be guilty of misconduct for letting a patient die.

239 Sec 15A(g-h).

240 Sec 15B.

241 Sec 41.

242 Sec 42(1).

It was made clear by Fabricius J in the High Court ruling of *Stransham-Ford*[243] that the health care practitioner who acceded to the request of the applicant to provide or assist the applicant with a lethal agent to end his life will not be subject to prosecution of the National Director of Public Prosecution or to disciplinary proceedings of the Health Professions Council of South Africa.[244]

This, however, was contested in the Appeal where the Supreme Court of Appeal found that nowhere in common law or the Constitution is it allowed to develop the law for an individual and not for the rest of society. Thus, the health care practitioner would not be exempted from criminal liability nor his/her professional obligations should s/he assist Adv. Stransham-Ford in obtaining or consuming a lethal agent.[245]

Thus, following the ruling of the Supreme Court of Appeal, a health care practitioner could have an inquiry instated against him/her by the HPCS or PBEC should s/he not follow the professional obligations.

5.10 PRE-HOSPITAL AND EMERGENCY MEDICAL CARE

At this point it should be perceptible, but be restated, that pre-hospital emergency medical care differs from in-hospital emergency medical care.

Upon admission of a patient, in a health care facility for in-hospital care, a patient file will be opened, and the file will be placed by their health care facility bed which contains their medical history and current treatments. Furthermore, it is possible to place a DNAR order in the patient's file and/or a notice by their bed for rapid recognition. The treating health care facility personnel also have access to the patient's records and any health care advance directives made.[246]

Pre-hospital patients are a variety of patients. Patients only in need of CPR may vary from trauma patients to medical patients, meaning a person involved in a motor vehicle

243 *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (6) BCLR 737 (GP).

244 *Stransham-Ford v Minister of Justice and Correctional Services and Others* 26.

245 *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others*:46(68).

246 http://www.netcarehospitals.co.za/Patients/Patient-journey (accessed on 17 October 2017).

accident and due to the trauma may be in need of CPR, or a person who suffered a lightning strike.[247] Medical patients vary from patients having cardiac arrests due to some underlying medical condition, unknown to them or patients who are terminally ill and at home in their last days, and as such prone to suffer from a cardiac arrest.[248]

Although all the above differ, one thing these patients have in common is the fact that the emergency health care practitioner dispatched to the emergency has no medical history of the patient, and all relevant information has to be obtained upon arrival.[249]

In the event of a cardiac arrest, the initiation of CPR is of dire importance to avoid brain damage due to a lack of blood flow and oxygen to the brain.[250] Thus, when considering DNAR orders for patients in the pre-hospital context, one would have to consider an easy identifiably product and it should be uniform throughout the Republic since the core functions for emergency medical care is, as mentioned earlier, early detection of an incident and the reporting of the emergency to the relevant authorities so that the correct level of care is dispatched.

After an emergency is reported, an emergency medical team will be dispatched to the location of the emergency and the dispatched emergency medical team will provide the best possible care at the scene.

Once the patient has been loaded into the ambulance to be transported, the patient care does not stop but is ongoing until the patient arrives at a health care facility, where the patient will be handed over to the receiving medical staff.

Therefore, the first thought of an emergency health care practitioner is not to consider a patient refusing emergency medical care, but to provide emergency medical care when called out to do so. When a patient wishes the contrary, it should be easily recognisable.

247 Sanders 2012:1142.

248 Sanders 2012:713.

249 Sanders 2012:491.

250 Geocadin, Koenig, Jia, Stevens and Peberdy 2008:488.

5.11 CONCLUSION

South Africa does not have legislation governing health care advance directives nor DNAR orders, which places both the patient and the health care practitioner in an uncertain position. The patient does not have the certainty if s/he issues an advanced directive that it will be adhered to nor does the health care practitioner have certainty that if s/he adheres to a health care advance directive, to forgo CPR, that they will be free from prosecution.

Through research it has become clear that patients should have the right to refuse medical treatment and this right is emphasized in several sections of the Constitution. Past cases also give a clear indication that patients want to be able to make their own decisions regarding medical treatment, and the refusal thereof. The problem that we are facing is that no concrete legislation governs this right.

Form a health care practitioner's perspective, one also needs to understand their position, since there is a duty imposed on them, by the Constitution, not to refuse a person emergency medical care[251] and because of the fear of being accused both criminally and delictually, the health care practitioner would be in a definite legal uncertainty.

Clear guidelines could be developed at first, but as seen in the UK context, it poses the possibility of abuse, and legislation would be the better and more concrete solution.

251 Sec 27(3).

6. CORE ETHICAL PRINCIPLES AND THE LAW

6.1 INTRODUCTION

In South Africa, there is no legislation to regulate or to enforce the use of health care advance directives.[252] At this point, it is quite clear that a health care advance directive, more specifically a DNAR order, is a relatively new development, but a contemporaneous development none the less as it forms part of recent discussions held regarding end of life decisions and the changing perception of end of life decisions of society.

Although no legislation regulates or enforces the use of health care advance directives, one can rely on the ethical principles created to give effect to specific human rights and in return these specific human rights give effect to the ethical principles. One can even consider whether the effect given to ethical principles by human rights should not make these ethical principles legally binding.

The purpose of this chapter is to identify the relevant ethical principles and discuss how these principles find application to health care advance directives and how a health care practitioner, specifically an emergency health care practitioner, should apply the known ethical principles to the scenario where a DNAR order might be present.

6.2 ETHICS

A vast number of definitions can be used to define the term “ethics”. For this study, a straightforward, layman explanation will be used. Ethics concerns the moral choices people make, the “good” and the “bad” choices. Thus, ethics is a study of morality.[253] Due to the nature of the subject being studied, namely morality, no certain of concrete answer can be given to an ethical dilemma. Through study and theories, one can come to be as close as possible to the best solution, but due to so many variables, in practice, the solution and the result may differ vastly form the theoretical solution.

252 McQuoid-Mason 2013:224.

253 Dhai and McQuoid-Mason 2011:3.

Ethics might be considered to prescribe higher standards than the law, especially in the health care context.[254]

6.3 THE CORE ETHICAL PRINCIPLES

Four core ethical principles have been identified over time and could be considered the four core ethical principles that should always be considered, apart from other relevant ethical principles as well, when dealing with an ethical dilemma. Respect for autonomy, non-maleficence, beneficence and justice are the four core ethical principles and also known as the Georgetown Mantra.[255] Balancing these four ethical principles should lead to a solution or the best possible solution to an ethical dilemma.[256]

The principle of respect for autonomy refers to the decision-making capacity of a mentally competent patient and takes into consideration the self-determination of a patient.[257]

The principle of non-maleficence is used where a health care practitioner should avoid doing harm or do as little harm as possible to the patient in order to care for the patient.[258]

The principle of beneficence simply means to do good to others, in this context specifically to ensure the health care practitioner promotes the well-being of the patient and conducts his/her actions to the best interest of the patient and not promoting their own interest. The principle of beneficence requires positive conduct to take place and not simply wishing the best for the patient and not taking action to ensure that the best is given to the patient.[259]

The principle of justice should also receive proper consideration, since we experience scarcity in health care resources. Justice aims to ensure that scarce resources, such as health care, is allocated in a fair manner among all who need it. The care provided to one patient should also be available to another patient presenting with the same condition.

254 Dhai and McQuoid-Mason 2011:4.

255 Gallagher 1999:14.

256 Beauchamp and Childress 2001:12.

257 Dhai and McQuoid-Mason 2011:14.

258 Dhai and McQuoid-Mason 2011:14.

259 Dhai and McQuoid-Mason 2011:14.

Focussing on these four core ethical principles and the legislation giving effect to the four ethical principles, a more workable solution to an ethical dilemma should be found.

6.4 RESOLVING THE ETHICAL DILEMMA

The HPCSA has set out guidelines to resolve ethical dilemmas.[260] In the researcher's view these guidelines were written for the in-hospital setting, where more time is available in order to find a solution to the ethical dilemma. None the less, these guidelines create a good reference point to work from.

Firstly, it is important to formulate the problem and to determine whether the issue is an ethical dilemma or not.

Secondly, information should be gathered. It is suggested in the guidelines that authoritative sources should be consulted to see how practitioners generally deal with such a matter. In the pre-hospital setting this will be quite the challenge, since time is of the essence and it cannot be used to gather authoritative information. The only information to be gathered is what is important in the present in order to save the patient's life.

Thirdly, one should consider the options available. Alternative solutions can also be considered, if available.

Fourthly, a moral assessment should be made and the ethical content of each option should be weighed and considered. Asking certain questions might guide the health care practitioner in making the moral assessment. Questions may be what the consequences of each option would be, or which ethical principle would carry the most weight in the particular ethical dilemma. What would the health care practitioner want in similar circumstances and what does the health care practitioner think the patient would want?

Lastly, the health care practitioner should act upon his/her decision in a sensitive manner and always reflect on the dilemma afterwards in order to identify room for improvement, should a similar dilemma arise in the future

260 HPCSA General ethical guidelines for the healthcare professions 2016:3.

Applying these guidelines to the scenario where a patient is in cardiac arrest and a family member verbally states that the patient has a DNAR order, after CPR was initiated, but no written document can be found, will identify the challenges that one faces in the pre-hospital setting where the in-hospital setting can almost be considered a relaxed environment with sufficient time for decision making.

Firstly, the scenario can be identified as both an ethical dilemma and a legal issue. For now, the focus will be on the ethical dilemma.

Secondly, gathering information in the pre-hospital setting can be a challenge, since an emergency health care practitioner does not have the patient's record file with him/her. The only patient information which can be gathered is through communication with the patient or a family member if present. During a medical emergency, it is difficult to obtain all relevant and necessary information due to the fact that the patient as well as family members might be experiencing immense stress and many times there are no family members present to consult. A health alert bracelet will also contain some information such as known medical conditions and allergies. Furthermore, a medical emergency does not always occur at home, thus the patient will not always have all his relevant documentation with him/her. This differs from the in-hospital setting where one has access to the patient's chart with the necessary records and documentation.

Thirdly, the options available in this specific scenario is to either initiate CPR or not since the patient is in cardiac arrest.

Fourthly, the consequences of each option differ vastly. If the emergency health care practitioner decides to not initiate CPR due to the possibility of a DNAR order being present, the consequence will be the death of the patient. Should the emergency health care practitioner decide to initiate CPR, the consequence will be that the patient might experience return of spontaneous circulation (ROSC) only so that the emergency health care practitioner might find out that there was indeed a DNAR order present and should the patient be terminally ill, the patient will experience another cardiac arrest imminently. The ethical value to carry the most weight in this particular scenario will be the one of patient autonomy. Since there is no written direction as to what the patient would have wanted, it complicates matter.

Lastly, the emergency health care practitioner should decide whether to initiate CPR or not and act upon his/her decision. Due to the uncertainty of the consequences of each of the available decisions, one would, as an emergency health care practitioner be very reluctant to make a decision since there are no clear guidelines for the encounter with a DNAR order or any other health care advance directive.

6.5 THE LAW GIVING EFFECT TO CORE ETHICAL PRINICPLES

6.5.1 The Constitution of the Republic of South Africa 1996

The Constitution of the Republic of South Africa was created after South Africa became a democracy in 1994.

The Constitution provides for guidelines concerning core ethical principles. Human dignity[261] is to be considered one of the most important human rights and it is also emphasised in many sections of the Constitution.[262] In fact, in the very first chapter of the Constitution, it is stated that the Republic of South Africa is one, sovereign, democratic state founded on the value of human dignity,[263] and the freedom of security of the person.[264] This guarantees the right of everyone not to be treated in a cruel, inhuman or degrading way[265] and also that everyone has the right to bodily and psychological integrity, which includes the right to security and control over their body.[266]

Based on the Human Rights and principles found in the Constitution, further legislation was developed to give effect to the rights found in the Constitution.

6.5.2 The National Health Act 61 of 2003

As an attempt to establish a structured and uniformed health system within the Republic of South Africa, the National Health Act was passed into law. The National Health Act gave further effect and application of rights found in the Constitution.

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261 *Constitution of the Republic of South Africa*: sec 10.

262 *Constitution of the Republic of South Africa*.

263 Sec 1(a).

264 Sec 12.

265 Sec 12(e)

266 Sec 12(2)(b).

The National Health Act provides for emergency medical treatment.[267] It also focusses greatly on the obtainment of consent from the patient[268] as well as giving the patient the right to participate in the decision making regarding his/her health.[269] The Act also describes the duties of the users,[270] namely the patients.

6.5.3 The Health Professions Act 56 of 1974

The Health Professions Act was passed into law in order to allow for the establishment of the Health Professions Council of South Africa.[271] The Act regulates the registration of practitioners and their conduct.

From this Act, the HPCSA was given certain powers to regulate and prescribe the conduct of registered practitioners. The HPCSA aims to promote and regulate the relationship between registered practitioners in the interest of the public;[272] furthermore, the HPCSA intends to assist in the promotion of the health of the population of the Republic.[273] In order to achieve these objectives, the HPCSA was given the power to create rules on all matters deemed necessary by the council or practically necessary to meet the objectives of the Act.[274] One example of such is the ethical guidelines provided by the HPCSA.[275]

6.5.4 The Health Professions Council of South Africa

The HPCSA was established by the Health Professions Act.[276] The HPCSA was given certain powers and objectives. With these powers, the HPCSA created guidelines to be followed by registered health care practitioners. A total of 15 booklets were carefully complied, one of which specifically focusses on general ethical guidelines for the health

267 *National Health Act* 61/2003: sec 5.

268 Sec 7.

269 Sec 8.

270 Sec 19.

271 *Health Professions Act* 56/1974: sec 2.

272 Sec 3(b).

273 Sec 3(e).

274 Sec 4(d).

275 HPCSA General ethical guidelines for the healthcare professions 2016:2-3.

276 *Health Professions Act* 56/1974.

care professions.[277] As per view of the HPCSA that in order to be a good health care practitioner, one has to reveal commitment to good and proper ethical and professional practices. The ethical guidelines were presented to guide and direct the practice of health care practitioners and form an integral part of the standards of professional conduct against which a complaint of unprofessional conduct will be measured.[278]

Another booklet focusses on the guidelines for the withholding and withdrawing of treatment.[279] It serves as guidelines and an ethical framework for when a health care practitioner encounters the decision to withhold life-prolonging treatment. The HPCSA recognises the need of patients to die with dignity;[280] however, the basis used is clearly not that of the pre-hospital context. Out of the whole document; only two short paragraphs were dedicated to emergencies,[281] which merely state that should there be a life-threatening emergency and a delay in medical treatment would threaten the life of the patient, treatment should be initiated when no clear relevant information, stating the contrary, meaning the patient's wish not to be treated, can be obtained. Furthermore, it is also advised that the patient should be informed of the treatment provided to them, when consent was not obtained.

This is not a sound solution, since there are absolutely no guidelines that regulate or enforce the use of DNAR orders. Patients do not have the certainty that extraordinary measures, such as CPR, will not be used on them since it is not always possible to obtain this information in the pre-hospital field. No easy identifiable documentation or bracelet exists. Furthermore, informing a patient who might have had a DNAR order about the medical treatment provided to them, might not be in the best interest of the health care practitioner, especially since patients are handed over to health care facilities and usually not in the state where this information can be conveyed to them. Thus, the in-hospital health care practitioner would have to convey the information and deal with the fall out should the patient have had a DNAR order.

277 HPCSA General ethical guidelines for the healthcare professions 2016:2-3.

278 HPCSA General ethical guidelines for the healthcare professions 2016:i.

279 HPCSA Guidelines for the withholding and withdrawing of treatment 2016.

280 HPCSA Guidelines for the withholding and withdrawing of treatment 2016:1.

281 HPCSA Guidelines for the withholding and withdrawing of treatment 2016:3.

6.6 CORE ETHICAL PRINCIPLES AND THE LAW

6.6.1 Respect for autonomy

A very fine balance should be kept when respect for autonomy is concerned. It should not be excessively individualistic, focussed on reason nor unduly legalistic.[282]

When a person is granted autonomy, s/he will act freely in accordance with his/her self-chosen plan. The two key factors essential for autonomy is liberty, the independence from controlling influences, and agency, the capacity to take intentional action.[283]

To respect a person's autonomy will require that the person's right to hold views, to make choices and to take actions based on personal values and beliefs are acknowledged.[284]

To respect the ethical principle of autonomy is to recognise, as a health care practitioner, the duty to respect the freedom of patients to make their own decisions regarding their health care.[285] The Constitution of the Republic of South Africa makes provision for the acknowledgement of the principle of autonomy in several sections.

As mentioned earlier, s12(2) provides for the right to bodily and psychological integrity. This implies that a person has the right to consent to treatment and also has the right to refuse such treatment. Thus, a patient will be well within their rights to draw up a written document stating that they refuse CPR as a treatment in the instance of a cardiac arrest.

Section 11 provides for the right to life. It is not elaborated on and the question arises as to whether a person should be forced to live a life with no proper prospect and where the quality of life has been compromised to the extent that constant palliative care is required. Should a mentally competent person not be given the opportunity to ensure that s/he not be given CPR when the initiation of CPR would lead to a major compromised of quality of life? Also, should the patient decide to create a DNAR, it should be guaranteed that this DNAR will be adhered to when needed.

282 Beauchamp and Childress 2001:57.

283 Beauchamp and Childress 2001:58.

284 Beauchamp and Childress 2001:63.

285 Dhai and McQuoid-Mason 2013:38.

Shifting the focus from the Constitution towards the National Health Act[286] there is also evidence to be found that this Act gives effect to the core ethical value of respect for patient autonomy.

The National Health Act provides that a health care practitioner should inform a patient of his/her right to refuse treatment,[287] giving effect to the core ethical value of respect for patient autonomy.

The National Health Act also allows for a patient to participate in the decision-making process of his/her health care treatment.[288] This will imply that when a patient is involved in the decision making regarding his/her health care and/or treatment, s/he can decide not to have certain medical procedures or interventions done. This will in effect also address s7 of the Act stating that every patient should give consent prior to receiving medical treatment.

The Act also places a duty on the patient to provide the health care practitioner with accurate information pertaining to his/her health status.[289] This will include informing the health care practitioner about any known allergies to medication. It can also perhaps be stretched so far as to say that should a patient have specific preferences regarding his/her medical treatment, they should also make it clear. Thus, a patient should be allowed to have a DNAR order, but it will be their responsibility to ensure that the health care practitioner is informed of such decisions even when the patient is unconscious and unable to communicate with the health care practitioner.

Focussing on the general ethical guidelines for health care professions, the core ethical value of respect for patient autonomy is not individually defined, but respect for patients implies that a health care practitioner should listen to his/her patients and respect their opinions. Furthermore, the health care practitioner should not participate in the violation of human rights of patients and also not allow, participate or condone any actions that can lead to the violation of a patient's human rights.[290]

286 61/2003.

287 61/2003: sec 6(1)(d).

288 Sec 8(1).

289 Sec 19(b).

290 HPCSA General ethical guidelines for the healthcare professions 2016:6.

Thus, not adhering to a patient's DNAR order will lead to the violation of their human rights and the health care practitioner could land himself not only in trouble with criminal law, but with the HPCSA as well.

6.6.2 Non-maleficence

Primum non nocere - above all do no harm.[291] The concept of harm goes further than just mere physical injury to another person. It also includes harm such as the wronging of someone else or causing adverse effects to another's interests.[292]

The ethical principle of non-maleficence in broad terms includes not to kill someone, or no to cause pain or suffering. Non-maleficence also includes not to deprive others of the benefits of life. It is however important to understand that non-maleficence does not necessary imply the maintenance of biological life, nor does it require the initiation or continuation of treatment without considering the patient's pain, suffering and discomfort - which might be a result or continue after the initiation and continuation of the treatment.[293]

The Constitution recognises the ethical principle of non-maleficence and gives effect to it by specific human rights. S12 provides that no patient be treated or punished in a cruel, inhumane or degrading manner. CPR is cruel and painful; thus, if a patient has a DNAR order, it will go directly against the ethical principle of non-maleficence to initiate CPR on the patient.

Section 10 of the Constitution provides for human dignity affirming everyone in South Africa to have their human dignity be respected and protected.[294] CPR has the potential to restart the heart, but there is no guarantee that brain damage did not occur during the period when there was no circulation of blood or intake of oxygen. Thus, should the patient's heart restart, there is a possibility of him/her being of a lesser mental capacity. Having to be fed, bathed and unable to communicate properly strips one completely of one's dignity. Thus, should a patient have a DNAR order, it should be adhered to and the

291 Beauchamp and Childress 2001:113.

292 Beauchamp and Childress 2001:116.

293 Beauchamp and Childress 2001:135.

294 Dhai and McQuoid-Mason 2013:44.

health care practitioner should adhere to the DNAR order without the fear of any form of repercussion for adhering to the DNAR order.

The National Health Act provides that every patient should be informed, by the health care practitioner, about the range of diagnostic procedures and treatment options generally available to the him/her and also the benefits, risks, costs and consequences generally associated with each option.[295] None of these treatments should cause more harm than good to the patient and should the patient decide to not have any of the suggested treatments, the health care practitioner should adhere to the patient's decision.

The HPCSA specifically focusses on the patient's best interest or well-being in stating that a health care practitioner should apply their mind when making diagnoses and considering appropriate treatment.[296] This could indicate that when deciding, a health care practitioner should consider the amount of harm the treatment would bring to the patient and if the harm justifies the outcome.

The HPCSA also states that a health care practitioner should, in the event of an emergency, provide care within their scope of practice and competency.[297] This also allows for a patient not to be unduly harmed by a health care practitioner. However, all levels of emergency health care practitioners are trained to perform CPR, it is just the invasive treatments which are allocated to ILS and ALS levels. Thus, in the event of a cardiac arrest, all emergency health care practitioners will initiate CPR, unless the patient clearly indicated a DNAR order.

6.6.3 Beneficence

As a health care practitioner, one has the duty to contribute to the welfare of patients. It requires more than simply refraining from harming a patient, it requires a health care practitioner to take positive action in promoting the welfare of a patient. This is known as the ethical principle of beneficence.

295 Sec 6(1)(b-c).

296 HPCSA General ethical guidelines for the healthcare professions 2016:5.

297 HPCSA General ethical guidelines for the healthcare professions 2016.

One can distinguish between two principles of beneficence; namely, positive beneficence and utility.[298] When a healthcare practitioner provides benefits to a patient, it can be described as positive beneficence, whereas striking a balance between the benefits and the disadvantages of a procedure is known as utility.[299]

Should the ethical principle of beneficence, promoting a patient's welfare, be considered more important than the ethical principle of autonomy? As a health care practitioner, one has the obligation to fully disclose all relevant information to a patient regarding his/her care; furthermore, a health care practitioner should also always seek consent and have the highest regard for patient confidentiality. For some ethicists, these are based on the ethical principle of respect for patient autonomy, while others argue that it is based on the ethical principle of beneficence.[300]

Edmund Pellegrino and David Thomasma are of the opinion that the best interests of the patient are intimately linked with their preferences.[301] Thus, providing the patient the ethical principle of respect for patient autonomy, one also gives effect to the ethical principle of beneficence.

The Constitution of the Republic of South Africa provides in s27(1)(a) that everyone has the right to access to health care within available resources. S27(2) also stipulates that no one may be refused emergency medical care. Thus, in the event of a cardiac arrest, no one may be refused CPR, by a health care practitioner. However, should the patient clearly state that s/he does not want CPR through a DNAR, should their wishes not be adhered to?

Furthermore, the Constitution also provides in s32(1) that everyone has the right of access to information, indicating that a person should have access to his/her health records and should the patient wish to do so, add a health care advance directive to such records and/or a DNAR order.

298 Beauchamp and Childress 2001:165.

299 Beauchamp and Childress 2001:165.

300 Beauchamp and Childress 2001:176.

301 Pellegrino and Thomasma 1988:25.

The HPCSA makes clear reference to a patient's well-being and best interest. Health care practitioners are required to have their primary focus on the best interest and well-being of the patient. Furthermore, the health care practitioner should not allow their own personal beliefs or convictions to influence the care provided to their patient.[302]

6.6.4 Justice

Justice can be described as fair, equitable and appropriate treatment in light of what is due or owed to persons.[303] Injustices occurs when an unduly burden is placed on someone or when a benefit to which someone is entitled is denied.[304]

According to justice, an equal share should be given to each person also according to his/her need. The implications of this would be that should the health care practitioner adhere to a DNAR order and forgo CPR for one patient who meets the requirements in order to legally forgo CPR treatment, the same treatment should be given to another patient, irrespective of the health care practitioner's convictions.

The Constitution of the Republic of South Africa provides for the ethical principle of justice. S9 of the Constitution provides for equality and non-discrimination. Emphasising the statement made above, that should a patient have his/her DNAR order adhered to, it should be provided to another as well.

Considering the four core ethical principles, it is a challenge to identify which of the four should weigh more than the other. As a health care practitioner, one has the duty to adhere to the ethical principles provided, but the real challenge is when these ethical principles overlap or work against each other.

From a health care practitioner's point of view, one has the duty to ensure that the best possible care is provided to the patient in order to adhere to the ethical principle of beneficence. And at the same time, to not do any more harm than is necessary to the patient in order to adhere to the ethical principle of non-maleficence.

302 HPCSA General ethical guidelines for the healthcare professions 2016:5.

303 Beauchamp and Childress 2001:226.

304 http://www.jblearning.com/samples/0763760633/60632_CH02.pdf (accessed on 23 September 2017).

For a patient, especially where CPR and the decision to forgo CPR, for whatever reason, is concerned the ethical principle regarding respect of patient autonomy would carry the most weight. Also, when considering recent legislation, it would appear that the courts would rather favour a patient's autonomy irrespective of their role in society or even in a family. Thus, if a patient made his or her decision to forgo CPR in the form of a DNAR order and it is known to family members and documented properly, there should be no reason as to why a health care practitioner should not honour the DNAR order of the patient.

For the ethical principle of justice, one should keep in mind that the same treatment provided to one patient should be provided to another. Thus, if a patient had his/her documentation in order and the DNAR order was adhered to, the next patient, with similar circumstances, should be given the same treatment and certainty that his/her DNAR order would be honoured.

The National Health Act provides that a health care practitioner may not refuse a patient emergency medical treatment.[305] This connects directly with s27(3) of the Constitution where it is stated that no one may be refused emergency medical treatment. This gives effect to the ethical principle of justice where emergency medical treatment should be provided to all patients.

Cardiac arrest is considered to be a life threatening medical emergency and CPR, by default, should be provided to all cardiac arrest patients, with the exception of a massive casualty, where too many resources will be used on one patient and numerous others could be saved in the time used, and quantity is considered more important than quality.

Thus, to give effect to the principle of justice, all emergency health care practitioners will provide emergency treatment. Should a patient wish to not have such treatment, it should be clearly stated or indicated.

305 Sec 5.

The HPCSA does not give clear, focussed guidelines as to what is expected regarding justice. It is only mentioned that justice indicate that a health care practitioner should treat all individuals and groups in an impartial, fair and just manner.[306]

6.7 THE HIPPOCRATIC AND PARAMEDIC OATH

The Hippocratic oath is considered to be one of the oldest documents in history binding health care practitioners to a specified standard of conduct and although no certainty exists as to who first penned down the oath, it bears the name of Hippocrates, who is considered the father of medicine.[307] Despite the growing number of health care practitioners expressing the view that the oath has become inadequate to address the realities of the modern medical world, the oath, or a modernised version of the oath, is still sworn to by graduating students of medicine world-wide.[308] Similar to the Hippocratic Oath, emergency health care practitioners, especially advanced life care practitioners, also take a Paramedic Pledge.

Modern versions of the Hippocratic Oath state that as a health care practitioner, one would apply one's knowledge to the benefit of the ill. This should be done according to one's ability and judgement with the aim of keeping patients from any harm and injustices.[309] Similar to this, the Paramedic Pledge states that one would apply one's ability and judgement to the benefit of patients and abstain from harmful and ill-behaved conduct.[310]

From the Hippocratic Oath and the Paramedic Pledge, the ethical principles of beneficence, non-maleficence and justice finds application as all obtained knowledge should be used to the benefit of all patients, whereas any harm and injustices should be avoided. Although not legally binding, these oaths provide a moral sense of obligation towards both patients and the profession as it is pledged to a deity which can be

306 HPCSA General ethical guidelines for the healthcare professions 2016:2.

307 http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html (accessed on 21 November 2017).

308 http://www.hpcsa.co.za/Conduct/Ethics (accessed on 21 November 2017).

309 http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html (accessed on 21 November 2017).

310 https://helivac.co.za/paramedic-oath/ (accessed on 21 November 2017).

considered as equivalent to pledging to act morally. This provides that ethical principles are acknowledged and adhered to.

The HPCSA also acknowledges that ethics are defined as moral principles and that various ethical aspects are highlighted by the HPCSA and that the Hippocratic Oath is the oath to the medical profession that all practitioners swear to.[311]

The ethical principle of respect for patient autonomy has no recognition in the Hippocratic Oath or the Paramedic Pledge. Previously, medical ethics had been paternalistic, in terms of which the health care practitioner decided on the best interest of the patient. Beauchamp and Childress set out the four core ethical principles in 1994, which moved medical ethics into the direction of 'principlism'.[312]

The ethical principle of patient autonomy has led to the Hippocratic Oath falling out of favour as patient autonomy is considered to be one of the most important ethical principles, also seen throughout this study.

Thus, as noble as the Hippocratic Oath and Paramedic Pledge intended to be, they do not encompass all the required ethical principles and considerations of modern medicine. The oath can be considered as a guideline for the everyday character traits of a health care practitioner, but not necessarily their decision making. The Hippocratic Oath and the Paramedic Pledge, as such, does not provide sufficient guidance and therefore ethical guidelines should be taught to students and provided to health care practitioners through the relevant governing body such as the HPCSA.

6.8 CONCLUSION

Ethical principles and the law can be considered to complement each other and give effect to one another. From the four core ethical principles, it is clear that there are sufficient grounds for the justification of health care advance directives and DNAR orders.

Focussing on the health care practitioner and the situation s/he finds themselves in regarding health care advance directives and DNAR orders, it should be possible for them to adhere to these orders as long as there is written proof. A written DNAR order

311 http://www.hpcsa.co.za/Conduct/Ethics (accessed on 21 November 2017).

312 McClenaghan 2011:10.

should give a health care practitioner sufficient grounds to forgo CPR without the fear of being prosecuted by law or the HPCSA. Allowing the patient to enforce his/her DNAR order also gives effect to the core ethical principle of respect for patient autonomy.

As it is clear from the above that there are numerous sections in our Constitution and several other pieces of legislation, providing for and giving effect to the core ethical principles, one would like to reiterate the importance of developing legislation and guidelines for the use and enforcement of advance health care directives as well as DNAR orders. At this point it is suggested that guidelines be developed, and later on clear legislation, as this will be of benefit to both the patient as well as the health care practitioner.

For the patient, it will provide the peace of mind that should s/he have a cardiac arrest and be in need of CPR, but do not wish to have such interventions, they can be sure that a document or even a DNAR bracelet will convey their wishes.

For the health care practitioner, it will also provide the necessary confirmation that should s/he adhere to the DNAR order, they will not be prosecuted by authorities or the HPCSA. The health care practitioner will also be aware of the consequences should s/he decide to ignore the DNAR order and continue with CPR until the patient has return of spontaneous circulation.

In South Africa, there is no legislation to regulate nor to enforce the use of health care advance directives.[313] At this point, it is quite clear that a health care advance directive, more specifically a DNAR order, is a relatively new development, but a contemporaneous development none the less as it forms part of recent discussions held regarding end of life decisions and the changing perception of end of life decisions of society.

Although no legislation regulates or enforces the use of health care advance directives, one can rely on the ethical principles created to give effect to specific human rights and in return these specific human rights give effect to the ethical principles. One can even consider whether the effect given to ethical principles by human rights should not make these ethical principles legally binding.

313 McQuoid-Mason 2013:224.

The purpose of this chapter is to identify the relevant ethical principles and discuss how these principles find application to health care advance directives and how a health care practitioner, specifically an emergency health care practitioner, should apply the known ethical principles to the scenario where a DNAR order might be present.

7. IDENTIFIED DILEMMAS OF DNAR ORDERS

7.1 INTRODUCTION

Health care advance directives and DNAR orders are considered as contemporaneous, and it becomes more frequently observed amongst patients as DNAR orders form part of recent discussions held regarding end of life decisions and the changing perception of end of life decisions of society.

Current guidelines and legislation are lacking when it comes to the regulation of DNAR orders in South Africa, which causes concern as it creates legal uncertainty among health care practitioners as well as patients, which may inevitably lead to a slippery slope.

The legal positions of a health care practitioner relating to DNAR orders have been identified and discussed in detail and it was concluded that a health care practitioner could be found guilty of a crime such as assault when ignoring a DNAR order and initiating CPR on a patient. The health care practitioner could also be found guilty of murder when not initiating CPR on the patient when there is no evidence of a DNAR order and the omissio results in the patient's death.

For a health care practitioner to be held liable for damages in terms of the law of delict, for initiating CPR when there was a DNAR order in place currently seems unlikely to succeed in court. However, this does not mean that a health care practitioner is immune from future delictual claims for damages which might succeed with the correct basis of claim, and thus creating a precedent.

Another key focus of this study is the ethical consequences of a DNAR order and the decisions pertaining thereto. Focussing on the core ethical principles of respect for patient autonomy, beneficence, non-maleficence and justice one can find several sections in legislation giving effect to these core ethical principles.

Arguably the most important will be the Constitution of the Republic of South Africa. Human dignity is to be considered as the cornerstone of human rights and the Constitution puts emphasis on this right, even in the very first chapter it is stated that the Republic of South Africa is one, sovereign, democratic state founded on the value of

human dignity.[314] This is followed by s10, granting everyone human dignity and s12, the right to bodily and psychological security.

The Constitution enabled legislations such as the Health Professions Act[315] as well as the National Health Act[316] providing frameworks for the professional conduct of health care practitioners and establishing a regulatory body known as the Health Professions Council of South Africa in order to protect the public against misconduct by health care practitioners.

The HPCSA also provides guidelines for registered health care practitioners ensuring professional and ethical conduct. Along with these guidelines, the Health Professions Act[317] also provided that the Minister shall, at the recommendation of the HPCSA, establish a professional board for a specific health profession,[318] such as emergency medical care. For emergency medical care the Professional Board of Emergency Care (PBEC) was established.

The PBEC was also given regulatory powers by the Health Professions Act,[319] in terms of which it can conduct an inquiry regarding a registered practitioner's conduct as well as impose the necessary disciplinary sanctions.

For the purpose of this chapter preidentified dilemmas will be considered and discussed, both ethically and legally.

7.2 GENERAL MEDICOLEGAL PROBLEMS ASSOCIATED WITH DO NOT ATTEMPT TO RESUSCITATE ORDERS

Before the general dilemmas are considered, the general concept of cardiopulmonary resuscitation will be restated.

314 Sec 1.

315 *Health Professions Act* 56/1974.

316 *National Health Act* 61/2003.

317 56/1974.

318 56/1974: sec 15(1).

319 Sec 41-51.

Cardiopulmonary refers to terms relating to the heart and lungs[320] and resuscitation refers to the technique one uses in an attempt to return spontaneous pulse and breathing to a patient, which includes interventions such as oxygen and airway management, insertion of an intravenous line to administer drugs or intravenous fluids and the administration of electrical therapy, known as defibrillation.[321] When a patient is in the terminal phase of an incurable disease, the final phase of a process leading irreversibly to death can be considered cardiopulmonary arrest.[322]

The fundamental goals of medical interventions are the preservation of life, the restoration of health, the relief of suffering, both physically and mentally, and the restoration or maintenance of function. These goals are often encompassed under the principle of beneficence.[323]

When a patient suffers a cardiac arrest and requires CPR, certain medicolegal dilemmas and conflicts arise when there is a DNAR order present. Apart from the general urgency of the situation, an added factor is the fact that providing or withholding CPR has life and death consequences.[324]

Considering the ethics, it should be argued that health care practitioners should consider the golden rule, stating that the health care practitioner should treat his/her patient in the same way as s/he, meaning the health care practitioner, would want to be treated should the roles be reversed. At this point, the opinion should be clearly stated that this approach should be considered very carefully since what is important for one person is not necessarily important to the next and this could institute a slippery slope. However, the ideal would mean that health care practitioners', especially physicians', efforts should be directed to preserving life, as the Constitution provides that everyone has the right to life[325] and it could be argued that the right to life forms the foundation upon which all other rights, such as the right to human dignity, are to be construed.

320 Stedman's 2004:237.

321 Sanders 2012:712.

322 Pacheco, Osuna, Gomez-Zapata and Luna 1994:462.

323 Snider 1991:665.

324 Pacheco *et al* 1994:462.

325 Sec 11.

The dilemma arising is that, together with the right to life, the right to bodily and psychological integrity along with the right to human dignity should also be considered. Without the right to life, these rights would however be pointless. Thus, the question arising is which right should be considered paramount? The right to life, or the right to bodily and psychological integrity, which gives effect to the ethical value of respect of patient autonomy?[326]

Allowing a patient to make decisions regarding his/her medical treatments we give effect to the right to human dignity.[327] Furthermore, by allowing a patient to make such decisions, the core ethical principle of respect for patient autonomy will also be given effect too. The core ethical principle of respect for patient autonomy allows for the patient to decide which treatment will be accepted and which will be rejected. Should the patient decide to refuse treatment, such decisions should prevail and be respected even if the decision appears wrong in the view of the health care practitioner or cause the loss of a limb or even cause death to the patient.[328]

Another dilemma a health care practitioner could encounter is family members believing that CPR will always be successful "as seen on TV" and would want the health care practitioner to initiate CPR even though a valid DNAR order might be present or when the health care practitioner knows that the CPR attempt would be futile and in reality, CPR has a poor prognosis for most patients at the end stages of a terminal illness.[329]

In an attempt to define a DNAR order and understand the concept thereof, Tomlinson and Brody[330] have identified three rationales for writing a DNAR order:

i. The procedure should have no medical benefit.

ii. The quality of life that would likely result after the cardiac arrest and the subsequent CPR would be unacceptable to the patient, even though survival might be prolonged.

326 Pacheco *et al* 1994:463.

327 Snider 1991:667.

328 Pacheco *et al* 1994:436.

329 Ferrell and Coyle 2006:565.

330 Tomlinson and Broody 1988:43-46.

iii. The current quality of life should be so poor that the patient (or his or her family, if the patient is incompetent) would not wish to take actions to prolong it.

Following these three rationales, effect will be given to the core ethical value of respect for patient autonomy and granting the patient's wishes not be resuscitated in situations where it will not be to the benefit of the patient, without the health care practitioner having a moral conflict of not providing the right emergency medical care as imposed by the Constitution.

7.3 ATTITUDES TOWARDS END OF LIFE TREATMENTS

Initially ambulance services, now better known as emergency medical services, were seen as mere transportation of patients suffering from an acute medical and/or trauma emergency. Ever since, emergency services and their role have been developed and are now inclusive of a broader scope of complex health needs of which palliative care is one.[331]

In 2016, a study was done in the UK in order to determine whether health care practitioners working in the pre-hospital field felt confident in dealing with end of life situations. Evidence suggested that emergency health care practitioners, in general, felt unprepared to attend to palliative emergencies, which could result in conflict of the emergency health care practitioner's role when attending to a palliative emergency and it was suggested that further education and training is needed.[332]

The study also provided that one of the main concerns for emergency health care practitioners was the validity of a document stating to not initiate CPR. Furthermore, it was also found that emergency health care practitioners were reluctant to attend to palliative care emergency calls in order to avoid conflict with families as well as possible litigation being instated against them.[333]

In order to prevent health care practitioners, especially emergency health care practitioners, being reluctant to attend to a palliative care emergency one should ensure

331 Brady 2014: 38.

332 Kirk, Crompton, Knighting and Jack 2017:72.

333 Kirk *et al* 2017:86.

that end of life care treatment is integrated in the training of emergency health care practitioners in South Africa. This can be done through the HPCSA and PBEC adding this as a training requirement from training institutions. Furthermore, emergency health care practitioners concerning them with the validity of documentation and avoiding conflict with family members or litigation can be avoided if proper legislation is created leaving no room for misinterpretation. Standardized forms will also ensure no confusion regarding the validity of a DNAR order.

In 2005, another study was done in Hong Kong to determine students' attitudes relating to DNAR orders. Students studying medicine as well as students studying other fields were included in the study.

The study provided that students studying medicine were more prone to agree with the provision of a DNAR order in situations where the patient did not want CPR or where the chances of survival were very slim. Furthermore, prior knowledge of a DNAR order tend to lead students to understand why a DNAR order would be adhered to in certain situations. It was also noted that the majority of students, combined, did not know of DNARs order prior to the study.[334] Furthermore, it appeared as if family wishes appear to play a very insignificant role in the decisions to withhold or withdraw treatment, but the patient's wishes held most importance.[335]

As with all new concepts and treatments, it will be important to have a proper awareness campaign to the public, which might place a financial burden on the government. However, this should not be a reason as to why citizens cannot make their own decisions known regarding end of life care.

7.4 HEALTH CARE PRACTIONERS' RELUCTANCE TO INITIATE CONVERSATIONS RELATING TO DNAR ORDERS

The actual decision and action, or in fact the omissio, to forego CPR lies with the health care practitioner. For this reason, some health care practitioners might argue that they do not need their patient's permission or opinion to withdraw or withhold treatment.

334 Sham, Cheng, Ho, Lai, Lo, Wan, Wong, Yeung, Yuen and Wong 2007:262-263.

335 Sham *et al* 2007:264.

This should be raised as a point of concern and potential abuse in South Africa. The question remains as to what extent the refusal of medical treatment should be respected. A comparison study was done between health care practitioners from England and France. It was found that health care practitioners from England tend to be influenced by a culture which places emphasis on respect for the patient's wishes, whereas health care practitioners in France tend to argue that the vulnerable person should be protected even if it is to the detriment of the patient's autonomy.[336]

The insignificant number of health care advance directives written has led writers Fagerlin and Schneider[337] to argue that health care advance directives have failed, due to small numbers indicating that only a few people are aware of health care advance directives or can articulate their wishes regarding medical treatment. Some patients do not wish to do so due to the fear of misinterpretation of their wishes.

The study done in England and France revealed that health care practitioners in England felt it important to discuss withholding or withdrawing treatment with their patients before the patient becomes unable to communicate his/her wishes.[338] In France, however, health care practitioners are of the opinion that they do not need their patient's opinion when the health care practitioner is of the opinion that the patient should not be resuscitated; where a health care practitioner has a strong opinion regarding the treatment decisions of a patient, they rarely consider the patient's will.[339]

In South Africa, it would be of great concern should health care practitioners decide to have an attitude of not needing to obtain a patient's opinion when it comes to withholding or withdrawing treatment. Human Rights has a very prominent stance in the Republic and to simply dismiss or ignore a patient's wishes relating to withholding or withdrawing treatment would be an absolute violation of the patient's Human Rights.

Hence, it should be reiterated that should legislation and guidelines be developed, it should be clear and not leave any room for misinterpretation.

336 Horn 2014:425.

337 Fagerlin and Schneider 2004:30.

338 Horn 2014:428.

339 Horn 2014:429.

7.5 MEDICAL EMERGENCIES AND DNAR ORDERS

As previously explained, a DNAR order indicates that resuscitation, especially CPR, should not be initiated or attempted on a terminally ill patient with a DNAR order. A DNAR order is not such a non-contemporary decision as one would like to imagine, through this study one could even argue that it is quite justifiable. However, medical emergencies exist where CPR or rapid defibrillation would be of great value to the patient's prognosis and recovery.

Two examples of medical emergencies which will benefit from CPR or rapid defibrillation are mentioned below and each will be discussed briefly.

The first will be an otherwise healthy patient (who created a DNAR order to avoid CPR in the instance where the prognosis will be very poor) who suffers from choking on a foreign object obstructing the airway.

Choking is an often-occurring medical emergency and the protocol for relieving a patient from choking is to firstly attempt abdominal thrusts, also known as the Heimlich manoeuvre; should this be unsuccessful, and the patient becomes unconscious the correct protocol to follow is to initiate CPR, more specifically chest compressions, in order to expel the foreign object.[340]

The second will be an otherwise healthy patient (who created a DNAR order to avoid CPR in the instance where the prognosis will be very poor) who was struck by lightning and suffers cardiac arrest due to the heart going into ventricular fibrillation (VF).[341]

About 30% of persons struck by lightning suffer cardiac arrest.[342] The treatment for cardiac arrest due to a lightning strike is CPR and rapid defibrillation.[343]

Thus, a health patient, with a DNAR order as a precaution, who suffers from either choking or a lightning strike and end up in cardiac arrest, pose an ethical dilemma for

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340 American Heart Association: Basic Life Support 2016:73.

341 This is a heart rhythm that can result into pulselessness. VF can be described as the heart 'idling' due to no organized ventricular constrictions taking place.

342 https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/part-3-ethical-issues/ (accessed on 25 October 2017).

343 Sanders 2012:644.

health care practitioners. The patient can easily be revived with little to no chances of lasting side effects, but the presence of a DNAR order prevents health care practitioners from providing such lifesaving treatment.

Careful consideration should be given as to whether a DNAR order, made by a healthy person, should include instances of choking and lightning strikes. It could be argued that health care practitioners should make an evaluation regarding the futility, but this places the patient back in the position of relying on the health care practitioner's values, which is what one would want to avoid when aiming for certainty.

Thus, is it fair to say that a patient creating a DNAR order also assumes the risk of not receiving CPR in the instances where the cause could easily be reversed? This does not seem just.

Another ethical dilemma posed is when an individual, who created a DNAR order, attempts to commit suicide, but is discovered after the deed but before the attempt becomes successful. Should this patient be provided with CPR should it be required to save his/her life?

The health care practitioner would want to save the patient and act in patient beneficence, whereas the patient's wishes are autonomy and not to be resuscitated. However, one would not know whether the patient created the DNAR order not to be resuscitated when s/he attempts to commit suicide, since suicide it is not a general topic of discussion.

Thus, should this mean that the core ethical value of respect for patient autonomy should be adhered to and the patient not be resuscitated in the event of a 'failed' attempt at suicide?

No clear answer can be provided for this question; however, it should be mentioned that the right to life[344] should be considered, which will have the effect that the patient be provided with CPR.

344 Sec 11.

It could be suggested that DNAR orders should be specific when written, but the question arising is whether this will further complicate matters.

A DNAR order has the possibility of being interpreted very broadly, which could also include palliative and comfort treatment. A DNAR order could also be interpreted in the narrow sense, which will provide that only CPR will be withheld.[345] This could lead to a patient receiving or not receiving intravenous fluid, since this is also regarded as fluid resuscitation.

Should a pre-hospital DNAR order be interpreted so broadly, it could lead to a patient not receiving effective care, because CPR is avoided. For this reason, it is suggested that the narrow approach be taken when interpreting a DNAR order - which will include CPR, intubation, defibrillation and cardioactive drugs being withheld.[346] This approach will also aid in avoiding confusion regarding what should be done and what should be avoided. The narrow approach will ensure that the patient is not denied other treatments available, which will be of benefit to the patient or comfort care - which does not involve CPR.

An even narrower approach could be considered, where a patient could specify that fluid resuscitation and intubation is allowed, but no CPR. This can be specified on patient files in the in-hospital environment, but to expect such a very narrow approach from an emergency health care practitioner would be difficult since the indication thereof on a DNAR bracelet or in-depth wording on a document would delay the initiation of such procedures.[347]

The protocol developed in Columbia for DNAR orders, as discussed in Chapter 3, indicated that a patient who requested a pre-hospital DNAR order would need to decide between either receiving CPR and intubation or to forgo CPR, which would also include forgoing intubation since it is regarded as part of resuscitation. It is not yet achievable to create a pre-hospital DNAR order which specifically indicates which treatments to initiate

345 Fitzgerald, Milzman and Sulmasy 1995:225.

346 Fitzgerald *et al* 1995:225.

347 Fitzgerald *et al* 1995:225.

and which to forgo and the suggested method remains the general narrow interpretation of a DNAR order.[348]

It should be kept in mind, however, that a clear distinction can be drawn between cardiac arrest and pulmonary arrest. With cardiac arrest, there will be absence of a pulse as well as breathing, or effective breathing, also known as gasping. In respiratory arrest, the patient would still have a pulse but no effective breathing or any breathing.[349] Thus, with respiratory distress there is no reason as to why a patient should not receive effective care, which will not include CPR as long as the patient has a pulse.[350]

Thus, creating a DNAR order poses a risk of choosing to forgo treatment which might have been helpful. A concrete answer to the question of patients choking or been struck by lightning, as well as the suicidal patient, cannot be provided at this point. It should be kept in mind that it is better to err on the side of preserving a life, rather than not saving a life.

7.6 DNAR TATTOO

A very possible obstacle in the pre-hospital setting will be the difficulty in locating DNAR documentation. A patient who is terminally ill at home with palliative care for his/her lasting days would have the documentation next to his/her bed or close by.

However, another person who has strong convictions regarding the refusal of medical treatment, might have a DNAR order, but not be carrying it with the person all the time.

In an attempt to avoid a situation where documentation cannot be found, and the initiation of CPR could be imminent, a patient might opt to have the words, abbreviation, or symbol tattooed on their anterior thorax.[351] This, although seeming as a probable solution, does not come without any ethical dilemmas.

A DNAR tattoo lacks clarity. Having the words “Do Not Attempt Resuscitation” tattooed across your chest, leaves little room for misinterpretation, but the once simple “Do Not

348 Fitzgerald *et al* 1995:225.

349 American Heart Association: Basic Life Support 2016:9.

350 Fitzgerald *et al* 1995:226.

351 Anywhere on the front of the chest.

Resuscitate", (DNR) term has developed into "Do Not Attempt Resuscitation", (DNAR) and even "Do Not Defibrillate", (DND) which poses its own problems because DND would imply that the patient would not want to be "shocked", but still leaves room for health care practitioners to interpret it as the patient still wanting chest compressions and artificial breaths to be administered during CPR.[352]

Furthermore, the abbreviation DNR or DNAR used as a tattoo might have a personal meaning for someone who has decided to tattoo this on his/her body to be reminded of a specific incident in their lives or a specific person, which will have nothing to do with the a DNAR order.

Due to the uncertainty brought on by a DNAR tattoo, it might cause emergency health care practitioners to inquire regarding legal documentation, when noticing a DNAR tattoo on a patient's chest. Should the documentation not be available, the emergency health care practitioner is advised to initiate CPR. Thus, the DNAR tattoo, although with the initial wish to increase certainty to the patient, might have the opposite effect.[353]

Also, a DNAR order should like all other medical orders be reversible, should the patient wish to reverse the order. Tattooing a DNAR on your chest will not be easily removable and should the patient wish to remove the tattoo it will be a costly procedure.[354]

It will be strongly advised to not allow patients to tattoo DNAR across their chests. Alternative means should be explored in order to have a DNAR order visible.

7.7 DNAR ORDERS AND PATIENT CARE

DNAR orders are specifically created in order to instruct the health care practitioner to forgo CPR when the patient is unable to inform the health care practitioner as such. One of the concerns is that patient care, in general, will decrease with the presence of DNAR orders.

352 Iserson 1992:309-310.

353 Smith and Lo 2012:1238.9

354 Smith and Lo 2012:1239.

In 1997, a study was done by the America Geriatrics Society, regarding the effect of a DNAR order on the health care practitioner's decision to provide life prolonging treatment, other than CPR for patients nearing end of life stages.[355]

The study revealed that the presence of a DNAR order had a negative impact on health care practitioner's intentions to provide life prolonging treatments that did not relate to CPR.[356] Furthermore, the study also revealed that a number of treatments were not provided to a patient, due to the presence of a DNAR order. This confirmed that health care practitioners were more likely to withhold certain treatments, even intensive care treatments, not relating to CPR, from patients who had a DNAR order.[357]

It is important to note that this was never the intention to cause patients to not have proper treatment when the DNAR order was initially created. It was stated and emphasized by two organisations that DNAR orders do not have implications for any other treatment other than CPR.[358]

7.8 CONCLUSION

The health care advance directive and DNAR order is becoming a frequently addressed topic and patients are likely to request such documentation. South Africa does not have legislation governing DNAR orders.

However, it is clear from current legislation and guidelines that DNAR orders can be allowed and regulated in South Africa. It needs to be proposed here that proper awareness and teaching be done relating to DNAR orders when being implemented. This can be done through the initial training of students in Higher Education Institutions and for already qualified personnel it would be suggested that it be implemented in Continuous Professional Development activities, which are mandatory for all registered health care practitioners.

Pre-existing ethical dilemmas regarding DNAR orders are identified, which can be used to evaluate and consider the implementation of DNAR orders in South Africa.

355 Beach and Morrison 2002:2057.

356 Beach and Morrison 2002:2059.

357 Beach and Morrison 2002:2059.

358 Beach and Morrison 2002:2057.

Furthermore, it can also be used when developing guidelines or legislation governing DNAR orders in South Africa in order to avoid creating further ethical dilemmas.

8. CONCLUSION

8.1 INTRODUCTION

This study was introduced with the scenario of an elderly patient who suffers from a cardiac arrest and is in need of CPR. Once CPR is initiated, the health care practitioner is informed, verbally, by the spouse that the patient has a DNAR order. Another family member indicates that they do not have any knowledge of such a DNAR order and the spouse also informs the health care practitioner that they cannot find the documentation.

As a registered health care practitioner, one's first intention, when seeing a person in distress, is to help the distressed person. When confronted with the notion that the patient would not want to be helped, one almost feels taken aback and would almost immediately start to tread carefully.

Treading carefully is due to the fact that, through the Constitution, there is a legal obligation placed on all health care practitioners to provide emergency medical care.[359] When not providing emergency care, when another is in need thereof, one could be accused of criminal conduct. Furthermore, an emergency health care practitioner is specifically trained to provide health care in emergencies.

When contemplating one's own view of receiving emergency medical treatment such as CPR, one might begin to understand why another person would not want to have such treatment.

However, a health care practitioner's personal views and morals should not influence one's decision of patient care, as it should always be in the best interest of the patient.[360]

Since 1992, Emergency Medical Care has been operating as an independent profession with its own professional board, the PBEC, and acknowledged by the HPCSA as a profession.

359 Sec 27(3).

360 HPCSA General ethical guidelines for the healthcare professions 2016.

As emergency medical care focuses on life-threatening emergencies, it is inevitable that cardiac arrests will occur often during one works as an emergency health care practitioner. As DNAR orders are becoming more frequent, it is reasonable to expect that they would also find their way into the emergency pre-hospital field.

Thus, the purpose of this study was to identify the need for clear guidelines for emergency health care practitioners when DNAR orders are present in the event of a cardiac arrest. Furthermore, it will have to be decided which level of care, namely BLS, ILS or ALS, will be able to address ethical dilemmas and make decisions and take action, should these dilemmas present themselves in a cardiac arrest situation.

8.2 INTERNATIONAL LEGISLATION

South Africa does not have any legislation or proper guidelines enforcing or regulating DNAR orders.

When exploring unmarked territory, *terra incognita*, the Constitution of the Republic of South Africa provides in s8(3)(b) that when a provision in the Bill of Rights is applied to a natural or juristic person, a court may in order to give effect to a right in the Bill, apply, or if necessary, develop the common law to the extent where legislation does not give effect to that right. Furthermore, s39 also provides that when the Bill of Rights are to be interpreted, a court must consider international law and may consider foreign law. Also, when developing the common law or customary law, every court must promote the spirit, purport and objects of the Bill of Rights.

In order to address the circumstances relating to DNAR orders, legislation and guidelines of the United States of America as well as the United Kingdom were explored.

8.2.1 The United States of America

The United States of America could be considered the leading example regarding health care advance directives and DNAR orders, as it does not only have court decisions, but legislation and guidelines as well.

In *Cruzan v Missouri Department of Health*[361] it was found, by the Supreme Court of the United States of America that legislation should be developed which enables patients to make decisions regarding his/her own medical treatment. This lead to the development of the Patient Self-Determination Act,[362] (PSDA). The PSDA allow patients to make their final wishes regarding medical care known and respected.

After the implementation of the PSDA the *Wright v Johns Hopkins Health Systems*[363] drew attention, specifically related to a patient's wishes not to be resuscitated in the event of a cardiac arrest. The court found that the patient's statements about a DNAR was insufficient to establish a DNAR and that the health care practitioner did not act wrongfully in the prolongation of the patient's life.

Referring to the *Cruzan v Missouri Department of Health* case, one is reminded of the South African *Clarke v Hurst NO and Others*[364] case where the patient underwent a medical procedure during which his blood pressured dropped and he went into cardiac arrest. After being successfully resuscitated, the patient was left in a permanent vegetative state due to the deprivation of oxygen to the brain during cardiac arrest.

The patient's wife applied to be appointed as curatrix with the powers to agree to or withdraw any medical interventions or procedures for the patient, on his behalf. She requested that the artificial feeding be ceased without being prosecuted. This was allowed setting the precedent for passive euthanasia.

Clare v Hurst NO and Others could have set in motion the development of legislation or guidelines pertaining to end of life decisions. Furthermore, this is to prove that end of life decisions and the refusal of medical treatment is a contemporaneous decision.

Cases have been brought before the courts of the USA, for the "wrongful prolongation of life", of which *Allore v Flower Hospital*[365] is to be considered as one of the well-known cases where a patient's living will was ignored by a health care practitioner and life

361 *Cruzan v Missouri Department of Health* 497 U.S. 261 (1990).

362 *Federal Patient Self Determination Act* 1990 42 U.S.C. 1395 cc (a).

363 *Wright v. Johns Hopkins Health Systems* 728 A.2d 166 (Md. 1999).

364 *Clarke v Hurst NO and Others* [1992] 4 All SA 763 (D).

365 *Allore v Flower Hospital* 699 N.E.2d 560, 561- 62 (Ohio Ct. App. 1997).

sustaining treatment was initiated to the patient. The court did, however, not grant the award for the recovery of medical costs and pain and suffering.

Thus, it can be argued that the cases set a precedent for not allowing patients to claim medical costs for pain and suffering under the "wrongful prolongation of life" claim, but this, however, does not ensure that future cases could not differ factually, and courts end up allowing claims for medical costs for pain and suffering under the "wrongful prolongation of life" claim. Thus, it is important to also protect health care practitioners from such claims through the proper implementation and regulation of DNAR orders, either through legislation or guidelines.

Following the implementation of the PSDA, DNAR orders were also requested from patients, in order to avoid legal uncertainty from both the patient as well as the health care practitioner. This led to States developing legislation specifically regulating DNAR orders. Some States even included pre-hospital DNAR orders in the development of legislation such as Chapter 154 of the Wisconsin Statutes and Annotations.[366], [367]

The legislation developed by the various States of the USA[368] should serve as guidelines for careful consideration when constructing concept legislation or policies regarding DNAR orders in South Africa. Furthermore, the methods used to easily identify a DNAR order, especially focussing on emergency health care practitioners, should also be considered in South Africa.

The most common form of identification is a DNAR bracelet. For instance, Montana, the District of Columbia as well as Virginia allow the use of DNAR bracelets. These DNAR bracelets are standardised in each State in order to be easily recognisable in the pre-hospital setting. The DNAR bracelet also shifts the responsibility to the patients. As long as the patient wishes to have his/her DNAR order to be active and respected, it is the patient's responsibility to wear the DNAR bracelet. The only responsibility the emergency health care practitioner would have is to check, during a primary survey, for any indication

366 http://docs.legis.wisconsin.gov/statutes/prefaces/toc (accessed on 2 November 2017).

367 Also including South Carolina http://www.scstatehouse.gov/code/t44c078.php (accessed on 30 October 2017).

368 Columbia, Montana, Virginia and Wisconsin.

of a DNAR bracelet, and then to respect the patient's wishes should the DNAR bracelet appear authentic.

King County in Washington and Los Angeles County allow for the use of a verbal DNAR order. Allowing a surrogate decision maker to convey a patient's wishes regarding resuscitation would alleviate the burden of paperwork for the DNAR order. However, the person with the surrogate decision-making capacity will have to prove that s/he is legally appointed, and this would once again entail paperwork.

A verbal DNAR order would not be recommended for South Africa, since this does not resolve the paperwork issue and it poses the possibility for abuse. South Africa is a multilingual country which also creates a hindrance when considering the use of a verbal DNAR order. Thus, another means, such as the DNAR bracelet system, should rather be considered.

8.2.2 The United Kingdom

The United Kingdom comprises four nations, which includes the whole island of Great Britain – England, Scotland and Wales, and the northern part of Ireland.[369]

None of the four nations have legislation providing specifically for DNAR orders, especially not pre-hospital DNAR orders which should guide emergency healthcare practitioners. However, health care advance directives are acknowledged and broadly governed by legislation in England and Wales.[370]

Although not governed by legislation the, UK uses guidelines to implement and regulate DNAR orders. This provides for a suitable comparative platform for South Africa as the USA has specific legislation to govern DNAR orders and the UK only uses guidelines.

Comparing the guidelines to legislation as provided in the USA, as well as comparing the dilemmas faced using each would serve as a good guide as to what the suggested approach for South Africa should be.

Both the USA and the UK court cases lead to the acknowledgement of health care advance directives and in turn DNAR orders. In most instances in the USA, the claims

369 https://www.britannica.com/place/United-Kingdom/ (accessed on 21 September 2017).

370 *Mental Capacity Act* 2005.

were based on the fact that health care practitioners did not adhere to a patient's wishes not to be resuscitated.[371] This was due to unclarity of a DNAR order and the health care practitioner opting to rather resuscitate. This led to claims based on the "wrongful prolongation of life", but the courts did not allow for claims for pain and suffering due to the "wrongful prolongation of life" by a health care practitioner.

In the UK, however, cases brought to court relating to DNAR orders[372] were not based on health care practitioners ignoring DNAR orders and initiating CPR, but rather health care practitioners placing DNAR orders in a patient's file without consulting family members, in the instance when the patient is unable to communicate his/her wishes.

Thus, there exists health care practitioners who would rather ignore a DNAR order when it is unclear and initiate CPR, and other health care practitioners who would be of the opinion that they do not need their patient's permission in order to place a DNAR order. Both of these are undesired outcomes one would not want when implementing DNAR orders; thus, a midway should be established for implementation in South Africa.

8.3 LAW, ETHICS AND DNAR ORDERS

After careful analysis of the legal and ethical position of DNAR orders in South Africa, it was found that there is no legislation to govern DNAR orders specifically. However, the Constitution along with the National Health Act[373] provides enough grounds to recognise a patient's right to make informed decisions regarding his/her own health care.

Along with this the core ethical principles provided by the HPCSA, respect for patient autonomy, beneficence, non-maleficence and justice, also allow and give effect to the patient's right to make informed decisions regarding his/her own health care. Thus, the need for the development of DNAR order guidelines and legislation has been identified.

However, this creates uncertainty for emergency health care practitioners when encountering a DNAR order in the pre-hospital setting. This being the possibility of an

371 *Wright v. Johns Hopkins Health Systems* 728 A.2d 166 (Md. 1999); *Allore v Flower Hospital* 699 N.E.2d 560, 561- 62 (Ohio Ct. App. 1997).

372 *R (Tracey) v Cambridge University Hospitals NHS Foundation Trusts & Others* [2014] EWCA Civ 822; *Winspear v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB).

373 *National Health Act* 61/2003.

emergency health care practitioner held liable in terms of criminal law for either ignoring or adhering to a DNAR order. Should the emergency health care practitioner ignore the DNAR order and initiate CPR, s/he can be found guilty of assault. Should the emergency health care practitioner adhere to an illegitimate DNAR order, s/he can be found guilty of murder for not initiating CPR and letting the patient die.

In order to allow for DNAR orders to be implemented, the protection and legal certainty of all health care practitioners should also be provided. In order to achieve this, it is the researcher's recommendation that the discussed proposal below be considered.

8.4 DILEMMAS FACED WITH DNAR ORDERS

Allowing for the implementation and regulation of DNAR orders will not be without dilemmas. As with other known medical procedures, health care practitioners might have a moral objection towards giving effect to a DNAR order. This, however, should not pose a threat to the patient since the health care practitioner is obliged to place the patient's wishes above his/her own personal beliefs.

Furthermore, definite, yet unforeseen, medical emergencies have been identified where the healthy patient will benefit from the initiation of CPR, such as a patient choking and rendered unconscious. Or a patient who was struck by lightning and whose heart went into cardiac arrest due to ventricular fibrillation. These serious, yet reversible, medical emergencies should not be included in the DNAR order, meaning that should this be the cause of the patient's cardiac arrest, resuscitative efforts should be initiated even in the presence of a legitimate DNAR order.

The same will apply to the suicidal patient. Should a patient attempt, and fail, suicide and is in need of resuscitation, resuscitation should be initiated, since it cannot be assumed that it was the intention of the patient not to be resuscitated in the event of a failed attempt at suicide.

A DNAR order should not influence the level of patient care received by patients. A DNAR order should not lead to patients not receiving non-resuscitation related, yet needed, care

as this is not what a DNAR order was intended for. A DNAR orders are only to indicate that CPR should not be initiated in the event of a cardiac arrest.[374]

Lastly, it is not advised to tattoo the abbreviation DNAR on your chest. When a patient is in cardiac arrest with no relatives around, there is no way to authenticate the meaning of the tattoo, as “DNAR” could also indicate the initials of loved one(s). This will lead to doubt in the legitimacy of a DNAR order and will lead to the patient being resuscitated even if the patient had a written and signed DANR order at home or somewhere else.[375]

Although dilemmas exist with DNAR orders, with proper legislation, guidelines and ethical reasoning, these dilemmas can be addressed in the correct manner - which will protect both the patient and the health care practitioner.

8.5 PROPOSED DNAR POLICY

Considering all the relevant identified information, it is clear that there is a need for DNAR orders as well as the protection of both health care practitioners and patients. The development of a policy governing DNAR orders should be a combination of legislation as well as guidelines. Legislation will provide the legal aspect such as acknowledging DNAR orders as a legally binding and enforceable order, and guidelines will provide the detailed implementation and requirements for health care practitioners and can include specific sections for emergency health care practitioners.

Guidelines are also more adaptive than legislation and can thus be more easily improved in order to remain current. Legislation can also prescribe that officially developed guidelines are to be followed and implemented.

8.5.1 Policy development

The policy to be developed is to create a system allowing a registered physician to issue DNAR orders should a patient request such an order. This should only be done after a discussion with the patient and an explanation of the consequences should be provided. It should also allow for the revocation of a DNAR order, should the patient wish to do so.

374 Beach and Morrison 2002:2057.

375 Iserson 1992:309-310.

It is also to create a system for easy recognition of a DNAR order for emergency health care practitioners.

Key points to be considered when developing a policy for pre-hospital DNARs can be listed as follows:[376]

- A standardized form of identification should be established in order to assure that DNAR orders will be easily identified and continuity of care will be assured throughout the Republic. This should also be an inexpensive form of identification.

- It should be made known to both patients, when creating a DNAR order, as well as to emergency health care practitioners that initial resuscitative attempts are indicated when the patient's wishes are not clearly expressed e.g. in the form of a completed DNAR order or a DNAR bracelet.

- The conditions under which a pre-hospital DNAR order will not be considered should be predetermined and emergency health care practitioners should be taught these conditions.

- The pre-hospital DNAR order policy should allow for exceptions to be permissible; these should include the revocation of the written DNAR order, the cancellation of the DNAR order via emergency health care practitioners when there is doubt regarding the validity of the documentation and also that emergency health care practitioners can provide CPR should it be necessary for the emergency health care practitioner's safety.

- The emergency health care practitioner should be provided legal immunity, through legislation, when implementing a valid DNAR order.

- The pre-hospital DNAR order policy should also indicate as to how education of emergency health care practitioners regarding DNAR orders would take place.

376 https://www.acep.org/Clinical---Practice-Management/-Do-Not-Attempt-Resuscitation--Orders-in-the-Out-of-Hospital-Setting/#sm.000azx8t815u5f9zwxa275go1yhru (accessed on 21 October 2017).

- The policy should prescribe as to which level of health care practitioners would be able to decide upon the implementation of the DNAR order in an emergency situation.

8.5.2 Implementation

A DNAR order should be a signed, written order provided by a health care practitioner, specifically a physician, after careful discussion with the patient informing him/her of the consequences of such an order.

After a written DNAR order has been signed by the physician, patient and a witness, the patient can continue to obtain a standardized DNAR bracelet which will be easily identifiable by emergency health care practitioners, and other health care practitioners when encountering an unconscious patient.

Should there be any doubt regarding the authenticity of the DNAR bracelet or the DNAR order itself the patient needs to understand that CPR efforts will be initialized until concrete proof can be provided to the satisfaction of the health care practitioner afore resuscitative efforts can be withdrawn.

Furthermore, during initial discussion with the patient, the patient should be informed that should s/he be found unconscious due to the effects of choking, a lightning strike or a failed attempt at suicide the patient will be resuscitated in an attempt to restore return of spontaneous circulation.

A DNAR order is not a death sentence and it is not a permanent order, for should the patient still be of a sound mind and wish to revoke the written DNAR order, it will be well within their power to do so. Legislation should only provide immunity from criminal prosecution should the health care practitioner adhere to a legitimate written and signed DNAR order. If there is any doubt regarding the legitimacy of the DNAR order the health care practitioner will not be required to adhere to the DNAR order.

South Africa has three levels of emergency medical care namely, BLS, ILS and ALS. It should be stated that at any level CPR can be withheld from a patient with a legitimate DNAR order, since BLS and ILS emergency health care practitioners are usually the first ones on scene and ALS emergency health care practitioners are not available in all parts of South Africa. However, should there be any doubt regarding the legitimacy of a DNAR

order, consultation between the crew on scene and a health care practitioner, either a physician or an ALS emergency health care practitioner should take place before a decision is made to either continue with CPR or withhold CPR.

The choice to withdraw CPR should still remain with the ALS emergency health care practitioner.

DNAR orders should be introduced at the biennial Emergency Care Society of South Africa and Emergency Medicine Society of South Africa conferences[377] to all attending emergency health care practitioners. Also, all registered health care practitioners are to provide an email address upon registration with the HPCSA and the online renewal of membership fees also requires the use of the health care practitioner's email address. Through this all relevant information regarding DNAR orders can be distributed to emergency health care practitioners.

All registered health care practitioners are required to attend continuous professional development (CPD) sessions annually in order to obtain a prescribed amount of both continuous educational units (CEU's) of which a specified amount should consist of ethics, human rights and medical law.[378] Using this pre-existing platform legislation and guidelines can be introduced to registered emergency health care practitioners.

Furthermore, legislation and guidelines for DNAR orders can also be included in the formal education and training of students at higher educational institutions.

Lastly, the public should be made aware of DNAR orders and as it will be the physician discussing and assisting in obtaining a DNAR order, the burden should also be placed on them to make their patients aware of DNAR orders.

8.6 PROPOSED PRE-HOSPITAL DNAR LEGISLATION

In order to provide legal certainty to both patients and health care practitioners, especially emergency health care practitioners, it will be important to provide legislation which will acknowledge, implement and regulate DNAR orders in the pre-hospital context. Legislation will provide the foundation from which guidelines can be developed, by the

377 http://www.ecssa.org.za/ (accessed on 2 November 2017).

378 http://www.hpcsa.co.za/Content/Docs/guidelines_2011.pdf (accessed on 2 November 2017).

HPCSA, which in turn has to be accepted by the Minister of Health in order to be enforceable and legally binding along with the relevant legislation. The use of guidelines will ensure that the information provided remains current and should changes be required, it can be updated without the need to go through the process of amending legislation.

The main focus of this study was not to develop draft legislation, but to identify the current position of the emergency health care practitioner with regards to a DNAR order and to provide guidance as to how the dilemma should be addressed in South Africa. Thus, a concept proposal of pre-hospital DNAR legislation is included. This was created using the current legislation available from the USA, which specifically focusses on the regulation an implementation of DNAR orders in the pre-hospital context.

DO NOT ATTEMT TO RESUSCITATE ORDER

Definitions

1. In this Act, unless the context otherwise indicates –

"AEA" means an Ambulance Emergency Assistant (ILS);[379]

"BAA" means a Basic Ambulance Assistant (BLS);[380]

"Do Not Attempt to Resuscitate bracelet" means a standardized identification bracelet that meets the pre-established requirements;[381]

"Do Not Attempt to Resuscitate Order" means a written order issued under the pre-established requirements to direct emergency health care practitioners not to attempt cardiopulmonary resuscitation on a patient for whom the order is issued if the patient suffers cardiac or respiratory arrest;[382]

379 Emergency Medical Services Regulations, Government Gazette No 39337. sec 1.

380 Emergency Medical Services Regulations, Government Gazette No 39337. sec 1.

381 *Wisconsin Act* 60: Chapter 154.17(1).

382 *Wisconsin Act* 60: Chapter 154.17(2).

"emergency health care practitioner" means a person registered with the HPCSA as a Paramedic, AEA or BAA;[383]

"EMS" means emergency medical services;

"health care practitioner" means any person registered as such with a governing professional body;

"paramedic" means a person registered as an advanced life support practitioner (ALS).[384]

"resuscitation" means cardiopulmonary resuscitation or any component of cardiopulmonary resuscitation, including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications and related procedures. "Resuscitation" does not include the Heimlich maneuver or similar procedures used to expel and obstruction from the airway or defibrillation when a patient is in ventricular fibrillation due to a lightning strike;[385]

Do Not Attempt to Resuscitate Order[386]

2. (1) No person except for an attending physician may issue a do not attempt to resuscitate order.

Do Not Attempt to Resuscitate Bracelet[387]

3. (1) A "do not attempt to resuscitate bracelet" is a valid indication, recognized by emergency health care practitioners, that a valid "do not attempt to resuscitate order" exist;

(2) A valid "do not attempt to resuscitate bracelet" shall:

383 Emergency Medical Services Regulations, Government Gazette No 39337. sec 1.

384 Emergency Medical Services Regulations, Government Gazette No 39337. sec 1.

385 *Wisconsin Act* 60: Chapter 154.17(5).

386 *Wisconsin Act* 60: Chapter 154.19(1).

387 *Connecticut General Statutes*. Title 19a: sec 19a-580d-4.

(a) be of a standard design approved by the Minister of Health;

(b) be affixed to the patient's wrists or ankle;

(c) display the patient's name as well as the attending physician's name;

(d) not have been cut, broken or visibly tampered with at any time;

Duties of emergency health care practitioners when presented with a "do not attempt to resuscitate order"[388]

4. (1) When dispatched to render emergency medical services, EMS personnel must not initiate any resuscitative measures if the patient has a "do not attempt to resuscitate order" or a "do not attempt to resuscitate bracelet";

(2) A "do not attempt to resuscitate order" should be presented to the emergency health care practitioners upon their arrival should the patient not be wearing a "do not attempt to resuscitate bracelet";

(3) Emergency health care practitioners are required to provide other forms of care other than resuscitative measures, such as palliative care.

Liability of the emergency health care practitioner regarding to a "do not attempt to resuscitate order"[389]

5. (1) No emergency health care practitioner may be subject to disciplinary proceedings, or may be subject to criminal or civil liability due to:

(a) good faith reliance on a valid "do not attempt to resuscitate order" presented to the EMS at the scene in terms of section 4(2) above or a visible "do not attempt to resuscitate bracelet" resulting in:

(i) the withholding of resuscitative measures;

388 *South Carolina Code of Laws*. Title 44. Chapter 78: sec 4-78-25.

389 *Wisconsin Act* 60: Chapter 154.23; *South Carolina Code of Laws*. Title 44. Chapter 78: sec 4-78-35.

(ii) the withholding of resuscitative measures already initiated, once a legitimate “do not attempt to resuscitate order” is presented;

(b) initiating resuscitative measures on a patient if the emergency health care practitioners were unaware of a “do not attempt to resuscitate order” or a “do not attempt to resuscitate bracelet” or when the emergency health care practitioners have reason to believe that the “do not attempt to resuscitate order” has been cancelled or revoked or where the “do not attempt to resuscitate bracelet” has been tampered with or removed.

(c) initiating resuscitative measures on a patient with a “do not attempt to resuscitate order” or “do not attempt to resuscitate bracelet” where it was necessary to alleviate pain or provide comfort care as in the event of:

(i) a patient suffering from an obstruction in the airway;

(ii) a patient who has been struck by lightning and is in cardiac arrest due to ventricular fibrillation;

(2) No emergency health care practitioner may remove or tamper with a “do not attempt to resuscitate bracelet”.

Full resuscitative measures required in the absence of an order or bracelet[390]

6. (1) Emergency health care practitioners shall provide full resuscitative measures as prescribed in the absence of a “do not attempt to resuscitate order” or “do not attempt to resuscitate bracelet” with the exception of:

(a) decapitation of the body;

(b) mortal disfigurement;

(c) presence of putrefaction; and

(d) obvious signs of *rigor mortis.*

390 *South Carolina Code of Laws*. Title 44. Chapter 78: sec 4-78-40.

It is now clear that the ethical and legal position of the emergency health care practitioner regarding DNAR orders in the pre-hospital context is very uncertain. It could either happen that the emergency health care practitioner be accused of assault for ignoring a DNAR order and initiating CPR or murder when an illegitimate DNAR order is adhered to and no CPR was initiated. This leads to a great reluctance and uncertainty to exist regarding DNAR orders.

The provided concept legislation should offer an idea as to what need be included in do not resuscitate legislation specifically focused on the pre-hospital context. The main aim is to provide that both patients and health care practitioners are protected and provided with the necessary legal certainty to ensure that the patient's wishes are adhered to through the use of a DNAR order and also, to ensure health care practitioners can adhere to such a legitimate order without fear of prosecution.

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