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Etička razmataranja u resuscitaciji – evropske preporuke

Ethical Considerations in Resuscitation - European Recommendations

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Apstrakt

Resuscitacioni pokušaji nemaju za cilj produženje života po svaku cenu, jer mogu samo produžiti proces umiranja. Idealno bi bilo unapred doneti odluku o tome da li je ispravno započinjati resuscitaciju, u okviru koncepta unapred planiranog lečenja.

Četiri osnovna principa medicinske etike su:
1. Dobrobit – ovaj princip najčešće znači da treba pokušati sa kardiopulmonalnom resuscitacijom (KPR), ali ako rizici prevazilaze moguću korisnost, može značiti da resuscitaciju ne treba započeti.
2. Neškodljivost – znači ne naštetiti. KPR ne treba nastaviti kod pacijenata kod kojih neće uspeti, kod kojih povoljan ishod nije verovatan, a postoji jasan rizik od povređivanja.
3. Pravednost – podrazumeva da ako postoje uslovi da se KPR može primeniti, onda bi trebalo da bude dostupna svima, bez diskriminacije na osnovu godina ili nemoći.
4. Autonomnost – dobro informisani pacijenti mogu samostalno odlučivati, umesto da to čini neko umesto njih.

Unapred donete odluke o odbijanju lečenja uvedene su u mnogim zemljama i naglašavaju značaj autonomnosti pacijenta. Resuscitacija se ne sme pokušavati, ukoliko je to u suprotnosti sa zabeleženim odlukama odrasle osobe sa očuvanom moći rasuđivanja koja je svesna posledica u vreme donošenja odluke. Važno je osigurati validnost te odluke, kao i da okolnosti u kojima se ta odluka sprovodi budu predviđene ili definisane u trenutku njenog donošenja. U slučajevima iznenadnog vanbolničkog srčanog zastoja prisutni obično ne poznaju situaciju pacijenta i njegove želje. Ako je odluka zabeležena, može biti nedostupna. KPR treba započeti i ostale podatke pribaviti kad bude moguće. Pacijenti imaju pravo odbiti lečenje i nemaju pravo da lečenje zahtevaju, ne može se očekivati da lekar leči pacijente i onda kada je to u suprotnosti sa kliničkom procenom. Mnogi pokušaji resuscitacije završavaju se neuspešno i potrebno je doneti odluku o prekidu KPR. Ova se odluka može doneti kada postane jasno da nastavak KPR neće uroditi plodom. Faktori koji utiču na odluku podrazumevaju istoriju bolesti pacijenta, ritam srčanog zastoja, odgovor ili izostanak odgovora na inicijalne resuscitacione pokušaje i trajanje pokušaja. Ponekad tokom resuscitacije informacije postaju dostupne i mogu ukazati na to da dalja KPR neće biti uspešna. KPR treba nastaviti dok se održava šokabilni ritam ili reverzibilni uzrok srčanog zastoja. Opšte je prihvaćeno da ako se asistolija održava više od 20 minuta u odsustvu reverzibilnog uzroka sa svim preduzetim merama napredne životne podrške, neće odgovoriti na dalju primenu KPR i razumno je prekinuti resuscitaciju.

Abstract

Resuscitation attempts are not aimed at prolonging life at all costs, as they can only prolong the dying process. It would be ideal to decide in advance whether it is right to start resuscitation, within the concept of pre-planned treatment.

The four basic principles of medical ethics are:
1. Well-being – This principle usually means that cardiopulmonary resuscitation (CPR) should be attempted, but if the risks outweigh the possible benefits, it may mean that resuscitation should not be started.
2. Harmlessness - means not to damage. CPR should not be continued in patients in whom it will fail, in whom a favorable outcome is unlikely, and in whom there is a clear risk of injury.
3. Fairness - implies that if there are conditions for CPR to be applied, then it should be available to everyone, without discrimination based on age or disability.
4. Autonomy - Well-informed patients can make their own decisions instead of having someone else do it for them.

Advance decisions on refusal of treatment have been introduced in many countries and emphasize the importance of patient autonomy. Resuscitation should not be attempted if it conflicts with the recorded decisions of an adult with preserved judgment who is aware of the consequences at the time of the decision. It is important to ensure the validity of that decision, as well as that the circumstances in which that decision is implemented are foreseen or defined at the time of its adoption. In cases of sudden out-of-hospital cardiac arrest, even those present are usually unaware of the patient's situation and wishes. If the decision is recorded, it may be unavailable. CPR should be started and other data obtained when possible. Patients have the right to refuse treatment and do not have the right to demand treatment, a doctor cannot be expected to treat patients even when it contradicts clinical judgment. Many attempts at resuscitation end in failure and a decision must be made to stop CPR. This decision can be made when it becomes clear that the continuation of CPR will not bear fruit. Factors influencing the decision include the patient's medical history, rhythm of cardiac arrest, response or lack of response to initial resuscitation attempts, and duration of attempts. Sometimes during resuscitation information becomes available and may indicate that further CPR will not be successful. CPR should be continued while a shockable rhythm or reversible cause of cardiac arrest is maintained. It is generally accepted that if asystole persists for more than 20 minutes in the absence of a reversible cause with all advanced life support measures in place, it will not respond to further CPR and it is reasonable to discontinue resuscitation.

Apstrakti uvodnih predavanja / Abstracts of the introductory lectures
XVIII Kongres Nacionalne asocijacije udruženja zdravstvenih radnika Srbije (NAUZRS). Vrnjačka Banja, 11–15. oktobar 2023.
XVIII Congress of the National Association of Health Workers of Serbia (NAHWS). Vrnjačka Banja, 11th–15th October 2023