



CASE STUDY

DO NOT ATTEMPT RESUSCITATION ORDERS IN PREHOSPITAL CARE

Issue

Inappropriate resuscitation of terminally ill patients.

ACEP Position

“Each emergency medical services (EMS) system should have a well-defined, comprehensive policy for dealing with out-of-hospital “Do Not Attempt Resuscitation” (DNAR) directives. Information regarding this policy must be widely disseminated among the public, prehospital personnel, and the medical community.

A comprehensive out-of-hospital DNAR policy must state whether prehospital personnel should honor a DNAR directive when the family member, the patient’s designee, or the patient’s responsible physician expresses a wish to initiate resuscitative efforts.

Prehospital personnel should initiate resuscitative efforts when called to the scene of a victim of cardiopulmonary arrest unless: 1) Obvious signs of death are found; 2) Valid DNAR documentation, consistent with local policy, is produced at the scene; or 3) The patient’s physician takes direct responsibility for withholding resuscitative efforts.”

The policy was approved by the ACEP Board of Directors in October 1998. An accompanying Policy Resource Education Paper, “Do Not Attempt Resuscitation Orders in the Out-of-Hospital Setting,” is available from the Sales and Services Department.

The “Ethical Issues of Resuscitation” policy statement approved in October 2001 is related to this topic.

Background Information

Until recently, EMS crews that responded to cardiopulmonary arrest in terminally ill patients had to provide full resuscitation. Even if the patients or their families desired only comfort care measures, it was difficult legally and practically for emergency medical technicians (EMTs) to honor this desire.

In the past few years, several states have instituted programs that allow EMTs to honor DNAR orders in the field.

Legislative History in South Carolina

South Carolina passed a bill allowing EMS recognition of DNAR orders in the field. The bill was prompted by a tragedy. A 7-year-

old cystic fibrosis patient arrested just as paramedics arrived, and resuscitation (required by law) was started. The paramedics had to continue even though a valid (hospital) DNAR order existed and the patient's physician told them to stop. The state Attorney General confirmed that the EMTs acted correctly under the law.

The Department of Health and Environmental Control (DHEC) then formed a task force that included the South Carolina College of Emergency Physicians (SCCEP), the South Carolina Medical Association, the hospital association, home health care representatives, nursing home representatives, emergency nurses, attorneys, and EMS systems. Proposed legislation took about one year to develop and was added to other legislation under the DHEC umbrella. It was introduced on February 4, 1994. The legislation passed out of the subcommittee on Senate Medical Affairs to the full committee, where it encountered its first opposition. Committee members did not feel comfortable allowing EMS personnel to decide when a person was dead. Pro-life advocates also believed that everything should be done to save a person's life. The committee gave the bill an "unfavorable" rating, essentially killing it.

The SCCEP began mobilizing its Key Contact System, targeting members of the Senate Medical Affairs committee. EMTs also were involved. These efforts succeeded, and the committee changed its recommendation to "favorable" after an amendment was added. The bill passed the Senate.

On the House side, a representative sponsored the bill and it went to the Judiciary Committee. The bill was tabled because the representative was unable to answer questions from the committee. It was not discussed in future meetings and essentially died.

Again, SCCEP and EMTs mobilized. With the aid of bill's Senate sponsor and the attorney for South Carolina Medical Association, pressure was brought on the House Judiciary Committee to schedule another meeting. Representatives were educated; the bill was discussed and brought to the House for a vote. It passed and became law on June 1, 1994.

Legislative History in Maine

Maine has a strong EMS law that essentially allows protocols to have the force of law. Maine instituted its "Comfort Care/DNR" program by protocol on September 1, 1994. The program uses bright orange bracelets and forms that identify a terminally ill patient to EMS providers. The forms, obtained from the state EMS office, are signed by the patient, family, and private physician, and are individually numbered.

Prior to enactment, many groups were invited to participate in the program's development. These included EMS systems and Maine ACEP, the hospital association, hospices, the medical association, home health care agencies, state elder and the adult services, social workers, and legal counsel.

Arguments in Favor of this Position

It has become common for individuals, and society as a whole, to realize that individuals have a right to have their wishes regarding resuscitation and dying recognized and honored.

Futile attempts at resuscitating a terminally ill person is a waste of human and financial resources and are physically and emotionally traumatic to those involved.

Courts are beginning to treat resuscitation of a terminally ill person as assault, and a number of "wrongful life" suits are currently in the legal system.

Cancer is the second leading cause of death in the United States, and in certain age groups AIDS is the leading cause of death. Many of these terminally ill patients are treated at home, and more are being encountered in the prehospital setting.

The encounter between EMS personnel and dying patients who have living wills or advanced directives can be emotionally charged and confusing. Having a clear pre-existing DNAR policy can prevent unnecessary resuscitation and inappropriate medical intervention.

Policies approved legislatively usually provide more protection to the EMS provider and the patient than do local system policies.

Prehospital personnel must have the option to resuscitate if they question the validity of a DNAR order.

A patient may revoke a DNAR order at any time.

Comfort care measures are given to a patient even though no resuscitative intervention is used.

An educational program should be instituted for patients, families, and the medical community regarding appropriate use of the EMS system.

Neither patients nor families have clear expectations of the death process. They are likely to be uninformed about the appropriate use of EMS systems without the education provided by a good DNAR program.

Arguments Against this Position

A DNAR policy may be used to allow untimely death of a patient.

A patient may have a sudden but reversible cause of arrest (eg, ventricular fibrillation from an electric shock) and be allowed to die because a DNAR policy is in place.

A family member may have ulterior motives in establishing a DNAR order for a patient.

Religious groups may believe that everything must be done to save a person's life.

Legislators may not feel comfortable allowing an EMT to determine death.

Family members may create confusion regarding their wishes versus the patient's during the final moments, leading to inappropriately given or withheld medical intervention.

Some patients believe that methods of identifying DNAR orders (eg, brightly colored bracelets) are stigmatizing.

Legislative History in Other States

Connecticut developed a system similar to that in Maine. States such as Virginia, New Hampshire, Maryland, Massachusetts, New York, and Montana have statewide policies and programs in place.

Potential Proponent Organizations

The state medical association, EMS organizations, nursing home associations, hospice associations, patient advocacy groups, organizations for elder patients (eg, the American Association of Retired Persons), Emergency Nurses Association, state hospital association, social workers, state elder and adult services, home health care organizations.

Potential Opponent Organizations

EMS groups, certain religious groups, and pro-life advocacy groups.

For more information on this issue,
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