

National Guidelines for Statewide Implementation of EMS "Do Not Resuscitate" (DNR) Programs

National Association of Emergency Medical Services Directors (NAEMSD)¹ and the National Association of Emergency Medical Services Physicians (NAEMSP)²

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Abbreviations: **AARP** = American Association of Retired Persons; **ACEP** = American College of Emergency Physicians; **ACS** = American College of Surgeons; **CPR** = cardio-pulmonary resuscitation; **DNR** = do not resuscitate; **EMS** = emergency medical services; **ENA** = Emergency Nurse Association; **NHTSA** = National Highway Traffic Safety Administration

Purpose

With the growth of hospice and home health care, more patients with terminal illness are electing to avoid hospitalization until the infal stages of illness. Many of these patients, as well as others with advanced chronic illnesses, have decided with the help and support of their attending

physicians that they do not wish to be resuscitated in the event of cardiac or respiratory arrest. However, as death draws near, well-meaning family or friends, or perhaps the patient, may call emergency medical services (EMS) personnel to transport the dying patient to the hospital; the prehospital providers who respond to these calls may be the last medical persons to attend terminally ill patients at home or in nursing homes. In many cases, these calls to EMS personnel are intended only to obtain transportation or comfort measures for the loved one. However, unless that state provides statutory authority for EMS personnel to honor a "do not resuscitate" (DNR) order, there may be a requirement for such personnel to attempt resuscitation, regardless of the patient's wishes and the physician's directive.

Over the last 10 or so years, there has been increasing attention paid to issues such as "living wills," "advance directives," durable powers of attorney, and "do not resuscitate" orders, with most of the focus being on care provided or withheld in an in-patient setting. The federal Patient Self-Discrimination Act,¹ effective 1 December 1991, has been the most comprehensive directive on this issue.

More recently, the EMS community has focused on the appropriateness and applicability of "do not resuscitate" orders in the prehospital or interfacility transport setting. "Guidelines for 'Do not Resuscitate' Orders in the Prehospital Setting" were published by the American College of Emergency Physicians (ACEP) in October 1988.² This was the first comprehensive discussion of important provision for EMS-DNR legislation and related EMS-DNR order forms. These guidelines were most helpful to states as they formally began to address this issue.

Another important step was taken in addressing the sensitivity issues related "do not resuscitate" orders in the field when the Emergency Cardiac Care Committee of the American Heart Association published the current "Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care, Part VIII: Ethical Considerations for Resuscitation."³ These guidelines include a provision for discontinuing cardiopulmonary resuscitation (CPR) when a valid no-CPR order is presented to the rescuers.

Over the last five years, there has been significant activity among the states to develop and implement EMS-DNR programs, including legislative changes, where necessary. The most recent review of current status of state policies in this regard can be found in original research by JG Adams, "Prehospital Do-Not-Resuscitate Orders: A Survey of State Policies in the United States."⁴ As of 1992, 11 states had specific legislation authorizing the implementation of EMS-DNR orders, six had legal opinions or policies allowing

implementation of EMS-DNR orders, and 14 states had working groups and/or legislation pending to address the issue.

It is the intent of this document to collect some of the best features of the statewide EMS-DNR legislation and programs that have been implemented across the country to date, and to suggest key points that should be considered in designing state legislation, developing and implementing EMS-DNR programs and protocols. These guidelines should encourage greater standardization of certain features of the various statewide programs, such as the information on DNR orders and bracelets, to foster reciprocal recognition and honoring of such orders across state lines. It is recognized that this may not be immediately possible, but it is believed that a proper foundation could be established on which to build in the future.

Guidelines for Statewide Implementation of EMS-DNR Programs

A comprehensive EMS "do not resuscitate" policy should be supported by both the state medical society and the state EMS lead agency. Wherever possible, it should have statewide applicability to reduce confusion for the public and to facilitate appropriate response regardless of local jurisdictional boundaries. In most states, it will be necessary, or at least desirable, to provide for legislative authority for such programs. Following is a review of recommended elements for consideration in developing EMS-DNR legislation.

EMS-DNR Legislation

EMS-DNR legislation should:

1. Define the conditions under which an EMS-DNR order can be considered;
2. Define which patients are eligible to be considered for an EMS-DNR order (It is recommended that eligibility be limited to patients with terminal conditions and other patients for whom a physician has issued a DNR order. This assures a medical determination of the appropriateness of such orders.);
3. Define which patient is competent to agree to such an order and define a mechanism for determining a surrogate decision-maker in the event the patient is not competent to do so;
4. Provide for this to be an informed decision made by the patient's physician, in consultation with the patient or surrogate;
5. Establish clear authorization for physicians to issue DNR orders;

6. Authorize EMS personnel to follow EMS-DNR orders, on-scene and interfacility;
7. Provide a clear definition of procedures to be withheld or withdrawn, or define the authority to develop such procedures;
8. Define the information that should be included in an EMS "do not resuscitate" order and other EMS-DNR identification items (if applicable), and the authority for designing such forms, etc. These items should be standardized on a statewide basis;
9. Establish periodic review of EMS-DNR orders by a physician to assure ongoing medical accountability. It is recommended that review be done annually;
10. Define a revocation process for EMS-DNR orders at the scene of a medical emergency;
11. Provide immunity from liability for those who do or do not carry out an EMS-DNR order, in good faith; and
12. Provide that neither an EMS-DNR order nor the failure of a person to have one executed shall affect, impair, or modify any contract of life or health insurance or annuity, or be the basis for any delay in issuing or refusing to issue an annuity or policy life or health insurance or any increase of premium therefore.

Legislation to allow for prehospital application of "do not resuscitate" orders should be incorporated with related legislation, such as a health care decisions act of similarly titled sections that deal with advanced directives. In some cases, there are more general provision for "do not resuscitate" order which may be honored by full range of health care providers, including EMS personnel. A good example of this is the Montana "Comfort One" Program.

A coalition to assist in the legislative initiative might include the state medical society, hospital association, bar association, hospice association, nursing-home association, ACEP chapter, AGS chapter, ENA chapter, fire and EMS organizations, specialty medical societies, and the state AARP.

EMS "Do Not Resuscitate" Order - Authorization Forms

A single, standardize, statewide EMS-DNR order form that is easily identifiable should be available for review by EMS personnel when they are

called to the scene of a "do not resuscitate" patient. At a minimum, such forms should include the following information:

1. A statement by the patient's attending physician acknowledging that the patient is in a terminal condition or is suffering from another medical condition, such as an advanced chronic condition, from which recovery is not expected;
2. Certification by the attending physician that: a) the patient is capable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment, or b) the patient has a written advance directive that directs life-prolonging procedures to be withheld under such circumstances; or c) the patient has executed an advance directive appointing an agent to make health care decisions on his/her behalf; or d) the patient has not appointed such an agent by advance directive, but there is an authorized decision-maker;
3. An expression of the patient's wish that in the event of cardiac or respiratory arrest that no resuscitation efforts be undertaken;
4. Signature and emergency telephone number of the responsible physician;
5. Signature of the patient or the patient's authorized decision-maker,; and
6. An issuance date and an expiration date. It is recommended that renewal be required at least annually to allow for review of the patient's medical prognosis and the decision to withhold resuscitation.

Distribution of EMS-DNR forms should be limited to health care providers, and the execution of such forms should be limited to the patient's attending physician. It is recommended that the original of the form be distinguishable from copies and that only the original be honored for purposes of withholding resuscitation.

Other EMS-DNR Identification Items

Some other unique forms of identification of DNR status, such as wallet cards, bracelets, or necklaces, may be used in addition to the official EMS-DNR order to facilitate recognition of a DNR candidate. This is helpful, especially when there is no one at the scene who knows the location of the EMS-DNR form.

There are several types of bracelets or wrist bands in use across the country for this purpose. For example, Montana uses a "Comfort One" bracelet,

which is actual jewelry with the unique "Comfort One" symbol. California has adopted the "Medic Alert" bracelet, with special DNR instructions. Virginia and several other states use a white, hospital-type wrist band with the "Star of Life" and "EMS-DNR" printed in blue. As of this writing, the use of the Star of Life for this purpose is still under consideration by the National Highway Traffic Safety Administration (NHTSA).

It is recommended that such bracelet or similar identification item include: 1) information that identifies the patient; 2) the physician's name and phone number (if possible); and 3) the expiration date of the order. There should be a long-range goal of achieving as much standardization of EMS-DNR forms and bracelets as possible among the states to facilitate movement of patients across state lines.

Statewide EMS "Do Not Resuscitate" Protocols

Standardization, statewide protocols should be developed to guide EMS response to this special category of patients. At a minimum, such protocols should address the following aspects of response:

1. Initial assessment and intervention;
2. Verification of patient identification for DNR;
3. Resuscitative measures to be withheld or withdrawn;
4. Comfort care or palliative care measures;
5. Documentation; and
6. Special considerations.

The medical treatments to be withheld or withdrawn should be articulated clearly. A "do not resuscitate" order should indicate that in the event of cardiac or respiratory arrest, cardiac resuscitation measures should be withdrawn. Measures to be withheld might include cardiac compressions, endotracheal intubation, or other advanced airway maneuvers, defibrillation, cardiac resuscitation medications, and support of ventilation.

Other medical therapies that might be indicated medically should not be withheld. Comfort-care measures that might be undertaken to ease these patient's suffering should be addressed. These comfort-care measures might include oxygen, suction, positioning for comfort, pain medications, and control of bleeding. It should be emphasized that an authorized EMS-DNR

order does not mean do not treat the patient or do not care. It indicates that there is a more appropriate and compassionate way to aid this patient than by using the traditional approach.

Special considerations should include discussion of under what conditions an EMS provider should not execute a "do not resuscitate" order. If there is a major confrontation with family members or others present, it may be best to perform normal resuscitative measures. Any difficult or confusing situations could be aided by contacting the on-line EMS medical director. It should be clear that if there is any doubt about the identity of the patient or the validity of the DNR order, providers always should err on the side of attempting resuscitation.

Comprehensive Education Program

Any new program of this consequence certainly needs to be explained thoroughly to all concerned. Initial planning should include provisions for a comprehensive education program for at least the following people and organizations:

1. All EMS providers, EMS instructors, and EMS medical directors;
2. Physicians, including component and specialty medical societies;
3. Other health care providers and institutions, including hospitals, nursing homes, hospices, home health care agencies;
4. Attorneys (especially those involved in elder law) and clergy; and
5. General public.

A very clear and concise videotape presentation can be very helpful for educating EMS agencies and their personnel. Your state medical society probably has a periodic journal or newsletter that could be used to communicate with physicians. A press conference and corresponding video news release is an excellent way to introduce such a program to the general public. In addition to the above, individual physicians should thoroughly discuss with any patients for whom a DNR order is being considered and/or with their family members, the implications of the order and how the EMS system could be expected to respond.

References

1. Amendments to 42 USC 1395 and 42 USC 1396, 1 December 1991.
- 2 American College of Emergency Physicians: Guidelines for do not resuscitate orders in the prehospital setting. *Ann Emerg Med* 1988;17:1106-1108.
- 3 Emergency Cardiac Care Committees and Subcommittees, American Heart Association: Guidelines for cardiopulmonary resuscitation and emergency cardiac care, VIII: Ethical considerations in resuscitation. *JAMA* 1992;268:2282-2288.
- 4 Adams JG: Prehospital do-not-resuscitate orders: A survey of state policies in the United States. *Prehospital and Disaster Medicine* 1993;8:317-322.