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Ethics of Emergency Medicine

AN ANALYSIS OF DILEMMAS POSED BY PREHOSPITAL DNR ORDERS

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☐ **Abstract—This article briefly recounts the development of the prehospital do-not-resuscitate (DNR) order and indicates certain situations, such as a choking episode or a suicide attempt, in which the presence of a DNR order may provoke a moral dilemma for the emergency medical technician as to whether or not the patient should be treated. An ethical analysis of this question is performed and concludes that resuscitative treatment is ethical and mandatory.** Copyright © 1997 Elsevier Science Inc.

☐ **Keywords—EMS DNR order; prehospital DNR; autonomy; resuscitation**

INTRODUCTION

There has been an increase in respect for autonomy within society. There is no need to recount the court decisions and changes in public attitudes that have caused increased recognition of an individual's right to refuse unwanted medical treatment (1). Almost no one questions the right of an individual to refuse life-saving or life-prolonging medical treatment. There has been a proliferation of documents, living wills, durable powers of attorney for health care, etc., that assist individuals in making their end-of-life decisions known. This essay will deal with a single example of this range of documents, the emergency medical service do-not-resuscitate (EMS DNR) order, and the ethical dilemmas it may pose in certain circumstances.[1]

The EMS DNR order was created to allow individuals to provide an advance directive to emergency medical technicians (EMTs) regarding their desire for or against resuscitative treatment (2), thus becoming one of the last areas of medicine to do so (3). The EMS DNR order, although an expression of individual wishes, is usually couched in the form of a physician order to ensure that EMTs will honor it.

The EMS DNR order is a document that attempts to remedy the shortcomings other advance directives present in prehospital decision making by providing a simple and rapid means of identifying those individuals who do not wish to be resuscitated. These orders have been implemented, by statute or regulation, in a number of states[2] and are pending in others.[3] The document

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[1] Although limited to the context of EMS, the situations occur elsewhere in medicine, such as the DNR patient who chokes on a piece of food in the hospital.

[2] The list grows almost daily. Currently, there are at least 25 states with some type of prehospital regulation allowing DNR: Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Kansas, Kentucky, Maryland, New Mexico, New York, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia, and Wyoming. (See also Adams JG. Prehospital do-not-resuscitate orders: a survey of state policies in the United States. Prehosp Disast Med. 1993;8:317–322).

[3] A consensus document to coordinate these efforts was created by a task force working under the auspices of the National Association of State EMS Directors (NASEMSD) and the National Association of Emergency Medical Services Physicians (NAEMSP) and released as the National Guidelines for Statewide Implementation of EMS "Do Not Resuscitate" (DNR) Programs (Prehosp Disast Med. 1994;9(2):67–69).

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typically directs responding EMS personnel that the holder does not want to be resuscitated if found in extremis. Presence of an EMS DNR order does not mean, however, that the EMTs will not provide comfort care, such as oxygen and control of pain.

There are two types of predicaments in which the EMS DNR order may provoke an ethical dilemma. The first one is an individual possessing such an order who suffers a sudden catastrophic, yet easily reversible, event that could prove to be terminal. The classic example is choking on a piece of meat or an anaphylactic reaction such as that caused by a bee sting. Each of these situations is often easily treated and, if properly treated, will leave no long-term disability. The other situation occurs when an individual, having authorized an EMS DNR order, attempts suicide and is discovered before the attempt becomes successful. Both circumstances provoke the classic dilemma, where the ethical wishes of rescuers to act for the good of their patient, i.e., beneficence, run counter to the individual's autonomous wishes expressed in the EMS DNR order. The rescuer cannot satisfy both of these conflicting ethical principles.

The analyses of these dilemmas are somewhat different and will be dealt with in turn. First, however, it is important to review the ethical principle that is crucial to the analyses, respect for autonomy.

The right of autonomy is commonly stated in the phrase made famous by Judge (later U.S. Supreme Court Justice) Benjamin Cardozo as "every human being of adult years and sound mind has a right to determine what shall be done with his own body" (4). This right may also be stated in the negative as recognizing that "it is wrong to subject the actions (including choices) of others to controlling influences" (5). Respect for autonomy recognizes that an individual, having made a decision and having understood the implications of that decision, should have that decision honored. This autonomous decision may even cause personal harm, as in the decision to refuse care. The usual format of an EMS DNR order attempts to fulfill the criteria for an autonomous decision. Individuals are not coerced to make such an order, they are counseled as to the implications of the document (usually by a physician), and the documents are available only to individuals with decision-making capacity or to their surrogates.

Intervention is not only ethically permissible but required in the context of a sudden catastrophic, yet easily reversible event. Interpreting an EMS DNR order as a decision to refuse a brief, simple life-saving procedure is not appropriate. Holders of EMS DNR orders are not likely to have included these types of events within the scope of those interventions they wished to refuse. For a decision to be autonomous, an individual must understand the probable consequences of that decision. Most individuals envision the EMS DNR order as allowing them to refuse a complex hospital resuscitation and stay in the intensive care unit, and although we can foresee how someone would not want the prolonged hospitalization and suffering usually associated with these circumstances, it does not follow our experience that a reasonable person would refuse a brief, simple life-saving procedure. Because the individual did not foresee this type of "rescue," any blanket refusal of EMS interventions via an EMS DNR order fails for lack of prior understanding of this situation. Also supporting intervention is the recognition that most of these sudden catastrophic but easily reversible events cause death by suffocation, which I think is an awful way to die. Prevention of suffering is a strong stimulus to dictating that care be rendered on the grounds of beneficence. If the EMS DNR order, as the expression of the patient's autonomous wishes, fails to apply in these types of cases, then beneficence mandates treatment.

The case of attempted suicide is more problematic, but, again, treatment by EMTs is supported. Although it could be argued, analogously as above, that the EMS DNR order does not apply because of the "foreseeability" factor, there is an easier evaluation. Suicide is an affirmative act that requires a decision by the individual to undertake that act. Treatment is necessary because the individual must be returned to a level of functioning where it is possible to demonstrate that the decision to end life is truly an autonomous decision. If, for example, an individual is clinically depressed, mental deliberations are clouded by disease. If the patient is not clearly able to understand the decision, consequences, and alternatives, an autonomous decision is not being made and need not be respected. EMTs usually are not in a position to determine if a decision is autonomous, thus they should treat the patient by transporting the individual to a facility where a definitive evaluation and possible additional treatment may be performed. This need to transport, sometimes against the patient's will, has been codified in the law of some states.[4]

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[4] In New Mexico, for example, the law states "Any person may be transported to an appropriate health care facility by an emergency medical technician, under medical control, when the emergency medical technician makes a good faith judgment that the person is incapable of making an informed decision about his own safety or need for medical attention and is reasonably likely to suffer disability or death without the medical intervention available at such a facility" (§24-10B-9.1 NMSA 1978).

Although neither of these dilemmas is likely to occur commonly, they both provoke a significant amount of discussion among EMTs and other medical personnel. How much of this anxiety is driven by the fear of potential lawsuits or by the drive to do something for the patient is unclear. In any patient care circumstance, patient autonomy regarding treatment is paramount over a caregiver's desire to do good for the patient, which holds regardless of how inappropriate the patient's decision may seem to a caregiver. The wishes of the patient need to have been autonomous, however, and if there is any question, such as in the examples given in this article, it is appropriate for the EMT to err on the side of life and begin resuscitative attempts, regardless of the presence of an EMS DNR order.

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