Don't Save My Life: Do-Not-Resuscitate and End-of-Life Directives in the Context of EMS and Disaster Medicine

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Withholding cardiopulmonary resuscitation for an individual who has documented their desire not to be resuscitated is old history in prehospital care.[1,2] Honoring a do-not-resuscitate (DNR) directive is standard practice for Emergency Medical Services (EMS) providers, but it continues to present legal challenges that include proper patient identification, the validity of a DNR document or order, and possible misuse of the DNR system by caretakers and family members. Considering these challenges, much has been done in the past 25 years to assure proper system protocols and procedures are in place for EMS personnel to honor DNR requests in a moral and legally appropriate manner.

On the other hand, the mechanisms to address patients who may be infirm and desire DNR status are not well established in disaster planning, mitigation, and response.[3] In disaster planning and response, the management of those who are chronically ill and may have severe chronic pain or respiratory conditions pose unique problems. This challenge was experienced by this author while staffing a disaster operations center during evacuations from wild fires in California (USA). A common problem in the evacuation centers and other sites was palliative care and hospice patients who required arrangements for controlled pharmaceuticals (primarily narcotics and sedatives) to manage ongoing pain control. Addressing the needs of an increasing number of people with chronic disease and formal DNR status is important for disaster planning.

Similar to the challenges presented by DNR patients is physician-assisted suicide, which is becoming more accepted worldwide.[4] Physician-assisted suicide is defined as a physician providing medication or a prescription at the request of a patient with the understanding that the patient intends to use the medication(s) to end his or her life.[4] The concepts and ethical foundations for DNR have been worked out over a number of years, but the practice of physician-assisted suicide is newer and ethically controversial. Physician-assisted suicide is legal in the Netherlands, Belgium, Luxembourg, Colombia, and Canada.[4] Additionally, the practice is legal in five US states, including Oregon, Washington (state), Montana, Vermont, and California.[4] Physician-assisted suicide poses important challenges for EMS providers and disaster managers. Opposed to the usual DNR experience, those who are pursuing physician-assisted suicide are potentially encountered while alive and attempting the suicide. EMS dispatches for suicide as a chief complaint are common, and most often, the general suicide patient is acutely ill or injured or highly distraught when EMS arrives on scene. Determining whether someone attempting suicide is mentally distressed and requires treatment and resuscitation for medical and psychiatric evaluation versus someone who has established a legal right to commit suicide is a vexing situation for EMS personnel. This is particularly the case when it is considered that EMS responders only have seconds to react to emergencies and physician-assisted suicide likely presents as a complex situation upon arrival to the scene. Current EMS culture is that dispatch is to resuscitate a "person down" or preserve life in a rapid fashion. Because there is an EMS emphasis on rapid response, treatment, and transport times and usually the need to react immediately to an emergency medical situation, there is little time for establishing legality of one or the other action on the part of the patient. While it can be assumed that all who pursue physician-assisted suicide will assure EMS is not summoned, encounters for EMS personnel can occur if a bystander or caregiver is unfamiliar with the intent of a person who has initiated the "legal" suicide process. More difficult are settings in which the suicide is unsuccessful, despite taking medications, and a patient is in respiratory distress with suffering or having uncontrolled vomiting as a reaction to taking a large quantity of medication. No matter the reason for dispatch, to treat and transport or not act are difficult decisions in the moments of a field encounter with someone attempting physician-assisted suicide.

A recent clinical review published in the *Journal of the American Medical Association* provides data that can help emergency personnel understand the potential response to a physician-assisted suicide event.[4] The study showed that in Europe, there has been gradually increasing support by the public for physician-assisted suicide, while in the United States, there has been neither an increase nor decrease in support in the past two decades. More telling is demographic data for physician-assisted suicide cases. The median age group for physician-assisted suicide spans those 55 to 84-years-old with the major reasons for seeking physician-assisted suicide being fear of loss of autonomy and being less able to engage in activities making life enjoyable. Predictably, most of those seeking physician-assisted suicide suffered from cancer or neurodegenerative disease. Unpredictably, pain and concern about chronic pain ranked low in reasons for pursuing physician-assisted suicide.

It is important for EMS personnel to recognize the developing worldwide acceptance of physician-assisted suicide and to adjust EMS planning and response for this newly developing trend. In the same line of reasoning, disaster planners and managers should understand the increasing number of people within communities that are in hospice settings and/or have established DNR status or intent to pursue physician-assisted suicide.

Because physician-assisted suicide requires support by law in specific communities, EMS personnel should be aware of the legal status of the practice in their response area and understand the

https://doi.org/10.1017/S1049023X16000984 Published online by Cambridge University Press

requirements for establishing pursuit of physician-assisted suicide. If dispatched to the scene of a suicide, assessment and initial management should always be first priority until it is determined (likely rarely) that an individual is attempting legal physician-assisted suicide. When dispatched to the scene of a physician-assisted suicide, EMS personnel should assure patient physical comfort within the limits of avoiding resuscitation and provide solace for family and caretakers.

For disaster managers and planners, it is fundamental to accept that persons who are in hospice settings and maintain DNR or physician-assisted suicide status are a special (vulnerable) population within a community. While hospice and DNR patients may not expect to have life-saving measures provided, they do expect to have the right to maintain their dignity and comfort. To accomplish this task, those providers who provide hospice can be consulted and included in disaster planning and preparations.

Attention to helping someone die who has established that personal right is a mandate for EMS and disaster health and medicine, with particular attention required for preservation of personal dignity, comfort, and respect for all, including the patient, family, and responders.

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doi:10.1017/S1049023X16000984