Introduction

- Emergency Medical Services are a critical link in the care of acutely ill patients.
- Play a critical role in the regionalization and specialization of health care.
- The aging of the patient population also will lead to new challenges for EMS providers.
- Heightened difficulties when faced with decisions on initiating, continuing or stopping resuscitative measures.
Goals of This Presentation

- Provide an Overview of Current Advanced Planning Documents – Living Wills, DNR, POLST
- Case-based Presentation of Dilemmas Related to Advanced Planning Documents in the Pre-Hospital Environment
- Emerging Trends in Advanced Planning Documents with Implications in EMS

Advanced Directives

- Traditional - *little or no impact on immediate care*
  Health Care Proxy or Health Care Power of Attorney
  Living Will

- Actionable Medical Orders - *direct and relatively immediate impact on course of care*
  POLST Paradigm form (POST, MOLST, etc.)
  Do not resuscitate order
  Do not hospitalize, no feeding tube, etc.
The Seriously Ill or Frail Patient

- Frame discussion based on patient-centered goals for care (e.g., quantity vs. quality of life)
- Discussion should include likely contingencies for future medical treatment
  - Example: Patient with advanced COPD
    BiPAP ok?
    Intubation and mechanical ventilation in ICU ok?
    Feeding tube ok?
    Long-term mechanical ventilation if patient cannot be weaned ok?
    Would hospice be preferred to above?
- Ensure sound informed medical decision-making
- Conversation with Healthcare Power of Attorney and “family” as defined by patient
- Completion of POLST Paradigm form

**POLST Form**

- Cardiopulmonary clarifies type of resuscitation. Do Not Attempt Resuscitation assists clinicians in communicating odds about success
- Options give people the choice to decide later since issue of when to use antibiotics is complex
- Discussion about treatment preferences is required
- Clear instruction on when to transfer to hospital and use of intensive care
- IV fluids in Limited Additional Interventions section
- Artificial hydration and artificial nutrition both found here
- If any section left unmarked, the highest level of treatment must be provided
Weaknesses of POLST

- Incomplete forms
- Issues related to canceling POLST and who can do this
- Out of state forms
- Conflict with Advanced directives/Living Wills
- Omission of dialysis, chemotherapy, etc...
- If questions: call...
Legal Provisions in Pennsylvania on End of Life Care

- In 2006, Act 169 was enacted to clarify the legal aspects of end of life care in Pennsylvania.
- Key provisions include granting of authority to health care powers-of-attorney that would be the same as that of a competent patient, outlining of the hierarchy among family members as surrogate decision makers and clarification of authority of family in requesting the withholding or withdrawing of life sustaining treatment.
- As noted before, law requires explicit certification that the patient is end stage or permanently unconscious for a non-health care power-of-attorney to have the authority to withhold or withdraw life sustaining treatment.

Problems with the Legal Construct in Pennsylvania

- The distinction between a health care power-of-attorney and health care representative (next of kin) does not absolve physicians from requesting informed consent for other invasive or involved medical/surgical interventions.
- The determination of whether a patient is end-stage is often a function of medical decisions that are made well before decisions on life sustaining treatment.
- Not unique to Pennsylvania – 12 other states make a similar distinction and require certification of the patient being end-stage or permanently unconscious.
- While this may prevent the premature withdrawal of life sustaining treatment, can lead to practical impasses in the critical care setting.
Case #1

- You are called to the home of a 75yo Caucasian male with breathing difficulties.
- On arrival, he is diaphoretic and unable to speak except in choppy words due to his respiratory distress.
- His wife says he has CHF and would not want to be on a ventilator.
- Do you accept her statement? Does it make a difference if the diagnosis was cancer as opposed to CHF?

Resuscitation

- The most common ethical dilemma for EMS providers surrounds decisions on initiating resuscitation.
- In general we default to resuscitating patients in extremis.
- In the resource limited pre-hospital environment, contemplation of implications of this decision may simply not be possible.
- Similarly family statements may not be informed about whether this acute episode can be reversed.
Case #1

- Does prognosis matter?
- We have all seen patients where our better medical judgment is that resuscitation should not be initiated.
- Scattered case reports of EMS providers not initiating resuscitative measures even in the absence of written documentation.

Case #2

- You are called to the home of an elderly couple for an individual with altered mental status.
- Upon arrival, you are informed that the patient has dementia and has not been eating and drinking.
- He is grossly dehydrated.
- The patient’s wife states that he indicated that he did not want artificial means for nutrition and hydration when he reached this stage.
- Do you start the IV and transport for treatment?
Consent

• Three levels of consent – presumed, implied and informed
• For EMS agencies, the vast majority of interventions are in the presumed and implied categories.
• Little time for true informed consent, and the impairments of patients may preclude this.
• Informed refusal, however, can be frequently encountered.
• Ideally, documentation is present to guide your treatment decisions.

Case #2

• True case – elderly couple who decided that they would refuse food and water as their health deteriorated so that they could die together.
• EMS was called and refused to transport couple based on informed refusal.
• Couple was forced to leave assisted living facility and go to home purchased by family.
Case #3

- Respond to a 78yo female at her assisted living facility with Alzheimer’s with evidence of sepsis.
- Upon arrival, review POLST stating that full treatment measures are desired.
- At the bedside, patient’s son states he is power-of-attorney and that the POLST form is old, and that mother did not desire aggressive measures in this circumstance.
- As he states this, patient becomes acutely hypotensive and bradycardic. What do you do?

Overriding POLST

- One of the advantages of POLST is its explicit nature.
- A problem is that it is a snapshot of a moment in time.
- Patient’s condition can change, usually for the worse.
- A patient can override an advanced planning document at any time.
- When a surrogate decision maker can override an advanced planning document is not clear.
Case #3

- This is an easier case for EMS in some ways.
- Given the time constraints for action, it is likely appropriate to initiate resuscitation, explaining the constraints of a patient signed POLST.
- Does not solve the issue in the ED or hospital.
- Withdrawal = Withholding ... But Not Really

Case #4

- Arrive at skilled nursing facility for a patient with significant respiratory distress.
- He is malnourished, has an advanced cancer diagnosis and is tachypneic.
- He has a DNR/DNI order on his medication list, no official form – nursing facility say they will find it and fax to hospital.
- You initiate BiPAP, but en route, the patient arrests. What do you do?
DNR/DNI

- As with POLST, considered an actionable medical order.
- Unlike POLST, can be recognized and acted upon in the field by EMS in Pennsylvania when properly documented.
- Proper documentation is a signed order on a properly formatted form, ideally with a bracelet on the patient.
- However, this case is unfortunately common.

Case #4

- Have to differentiate the letter versus the spirit of the regulation.
- Given the patient’s condition, may be appropriate to forego further resuscitation measures.
- Slippery slope ... what conditions allow this judgment, especially in the field?
Case #5

- EMS is called to a home of an elderly woman with an advanced brain cancer who jumped out of a window.
- She is in arrest upon your arrival.
- She has left a suicide note stating that she did not want to continue her life given the advanced stage of her cancer.
- Family is not around, just a neighbor who found her.
- What do you do?

Suicide

- Suicide is generally considered an impulsive act due to psychological impairment.
- In most cases, a suicide note is not evidence of a reasoned judgment by a patient to forego medical treatment.
- We rely on professionalism as codified in a variety of places – codes of conduct, other sources – to justify initiation of treatment in these circumstances.
- Harder in the rare case where may be a thoughtful decision.
Case #5

- In EMS setting, given constraints of time, likely better to initiate treatment measures.
- Question then is how far do you go and for how long.
- Proportionality is a common answer in clinical ethics.
- Lean heavily upon your medical direction in these cases.

Emerging Trends in Advanced Planning Documents

- Incentives to Health Providers to Initiate Discussions with Patients on Advanced Directives (e.g., POLST completion upon hospital discharge)
- Public awareness of consequences of prolonged medical treatment
- More jurisdictions moving to consider physician-assisted suicide/medical assistance at end-of-life
- Will confront EMS with further dilemmas – e.g., how would you view an unsuccessful assisted suicide attempt?
Conclusion

- Do-Not-Resuscitate and POLST are useful documents that convey patient goals in the face of serious illness.
- Unlike Living Wills or Advanced Directives, have application in the acute and pre-hospital setting.
- Not perfect – clearly requires further evaluation and judgment by health care professionals.
- Likely will raise more issues as further jurisdictions move to raise the awareness of the necessity of advanced planning and other mechanisms in the face of end-stage illness.
- Best recommendation – advanced consideration of these scenarios by EMS agencies and protocols for how to address.