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David M. Sine MA

Safety Logic Systems, dsine@austin.rr.com

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EMS, Suicide, and the Out-of-Hospital DNR Order

David M. Sine, MA

SafetyLogic Systems

dsine@austin.rr.com

Abstract

Patient autonomy may be placed at odds with the “rescue mentality” of EMS personnel when they are summoned and an out-of-hospital do not resuscitate order (DNR) is in place. This is exacerbated when a valid patient DNR order and a patient suicide attempt exist concurrently. This paper explores the two medical ethics principles of autonomy and beneficence placed at risk and the moral considerations for EMS personnel when a valid out-of-hospital DNR, a patient attempt at suicide, and a call to 911 intersect in the same temporal period.

When Duties Collide: 911, Suicide, and the DNR Order

The ethics principle of patient autonomy may be placed at odds with the “rescue mentality” of emergency medical service (EMS) personnel when they are summoned and a valid out-of-hospital do not resuscitate order (DNR) is in place. This may be further exacerbated when a valid patient DNR order and a suicide attempt exist concurrently. The chief goal of this paper will be to explore the two medical ethics principles of autonomy and beneficence which are placed at risk when a valid out-of-hospital DNR, a patient attempt at suicide, and a call to 911 intersect in the same temporal period.

A typical DNR order, by now quite familiar to the biomedical ethicist or ethics committee member, may be issued within a hospital setting as a doctor’s order to prevent unwanted and unwelcome medical resuscitative interventions for patients who typically have an underlying fatal disease or illness and wish to decline resuscitative emergency care. If a patient lacks sufficient capacity for such a decision, it can be made by a surrogate deciding on their behalf. What may be less familiar is the out-of-hospital DNR (OOHDNR) that is issued by a physician to give similar guidance regarding medical interventions for EMTs, paramedics, and other EMS first responders.

Ethical dilemmas involving pre-hospital care are not rare. A 1992 study found that ethical conflicts arose in 14.4% of paramedic responses and most existing out-of-hospital DNR orders do not adequately anticipate the predicaments encountered by EMS personnel (Hall, 1997). Pre-hospital emergency care providers responding to calls for medical assistance may encounter numerous ethical dilemmas triggered by non-standard OOHDNRs, conflicting family opinions regarding withholding resuscitation, and unreasonable requests by bystanders (Hall, 1997; K. Iserson, 1998; Marco & Schears, 2003).

Prior to 1992, no statute specifically addressed physician's DNR orders, either in or out of the hospital. The legitimacy of the physician DNR order was inferred from position papers and informal reports, such as those of the President's Commission for Biomedical Ethics and the Hastings Center (Iserson, Sanders, & Mathieu, 1995). At present, only a handful of the 42 states that provide statutory guidance on OOHDNR protocols address the issue of an active act of suicide such as strangulation, over dose, or self afflicted trauma (Klugman, 2009; Sabatino, 1999). Those that do generally state that if EMS is summoned, an attempt at suicide that falls outside of a permitted physician assisted suicide will negate the OOHDNR.

Suicides and the EMS Duty to Rescue

While various states have historically listed the act of suicide as a felony, all were reluctant to enforce it and, although no federal law specifically prohibits suicide, it is still considered an unwritten "common law crime" in some jurisdictions and the condemnation of suicide is a consistent and enduring theme in American legal heritage (Washington v. Glucksburg, 1997). Although few unambiguous answers exist to the legality of suicide, it is prohibited culturally and suicidal ideation, if identified in a patient, is to be reduced. In addition, it is illegal either by statute or by case law in a majority of states to assist another to commit suicide (Adams, 1993). In Oregon, the first of only three states to permit physician assisted suicide (PAS) by either statute or judicial decision, it is only allowed under very tightly controlled circumstances that require a) that there be an underlying fatal disease or illness and b) that the patient be competent (i.e. have sufficient capacity). Despite the growing body of state laws and local protocols that provide pre-hospital providers guidance, the current approaches to OOHDNR vary considerably. As a result, some patients who have obtained a valid OOHDNR

may still receive unwanted medical interventions as a result of the EMS system being activated under certain circumstances.

The American Heart Association has long maintained that “except in narrowly defined circumstances...professional first responders are expected to always attempt BLS [basic life support] and ACLS [advanced cardiac life support].” Those circumstances are obvious signs of death, rigor, or a valid DNR order (American Heart Assn Guidelines for Cardio Pulmonary Resuscitation and Emergency Cardio Vascular Care. Part II: Ethical Issues, 2005; Ethical Aspects of CPR and ECC, 1994; K. Iserson, 1998). This is partly in conflict with some EMS protocols that require that an OOHDNR be honored (resuscitation withheld) unless there is suspicion of suicide. Other EMS medical protocols regard the OOHDNR as invalid and thus resuscitation is not withheld if there is a suspicion of either suicide or trauma. Still other jurisdictions, such as New York, maintain that OOHDNR orders are “not written (as a) condition upon the cause of death” and thus place patient autonomy and the right to refuse resuscitation ahead of all other competing medical trauma including suicide and possibly even homicide (New York State Department of Health EMS FAQ: DNR, 1999).

Protocols, guidelines, and statutes notwithstanding, one study of EMTs showed that nearly half the respondents (49.1%) ignored patients’ wishes regarding resuscitation because they had personal difficulty withholding care that they had been trained to provide (Adams, 1993). In a survey of Oregon EMTs, 6% stated that they never withhold resuscitation and 31% would want to make a field decision (i.e. exercise discretionary power) for a terminally ill patient who took an overdose to end their life(K Iserson, 1998). It has been found that when pre-hospital health care workers are called upon for help, they are unambivalent in their opinion concerning their moral obligation; they are compelled by duty to prevent a suicide and to

mitigate the result of suicidal acts (Sine & Northcutt, 2008). Clearly, the laws and guidelines concerning OOHDNR do not fully resolve the conflict for the pre-hospital caregivers who are confronted with a valid OOHDNR and a concurrent active attempt at patient suicide.

Family members or bystanders may also influence the decision to initiate resuscitation efforts either overtly or by their mere presence. In addition, it is possible that the relative or even friend has been granted surrogacy through a durable medical power of attorney and, thus, may have the legal right to revoke the OOHDNR. EMS pre-hospital personnel are often reluctant to not initiate or to subsequently withdraw resuscitation due to previous positive outcomes with rescue efforts that are witnessed by family members. Some EMS personnel believe that to not provide treatment and resuscitation may betray the public's trust that is placed in the emergency medical system. As stated by one member of a study "our experience is that family members at the scene of cardiac arrest usually observe resuscitation efforts, which may positively affect their impression of the care that was provided and their grief response" (Delbridge & et al, 1996). Paramedics provide care in a particularly public setting and are trained to "treat the whole scene" and to actively engage in situational awareness while providing treatment (Sine & Northcutt, 2008). This "wider view" gives weight to the needs and interests of the community and the health care of each of its members. A "communitarian" application of beneficence that includes family and bystanders is possibly utilized and decisions to begin, withdraw, or continue emergency treatment often include more considerations than would a completely patient centered care perspective. No matter who has made the 911 call, arriving EMS personnel are often confronted with rapid and acute changes in a patient and have only seconds to determine the patient's resuscitation status. Thus, initially starting resuscitation efforts and then suspending them only after proving to be unsuccessful may be an attractive choice for EMS first responders.

Patient Autonomy and the Right to Refuse Treatment

The biomedical ethics principle of patient autonomy and the negative right to refuse care are placed at risk if a valid OOHDNR order is set aside by EMS personnel. Autonomy, establishes, among other things, the right of a patient to refuse care and this negative right can be expressed through a patient's advance directive and formally issued as a physician order through the DNR or OOHDNR. However, patient autonomy has always been based to some extent on a presumption of a patient's capacity to understand the consequences of a proposed action. Even in an era of patient centered care, not all patient choices are patent and some patient choices are not accepted if the patient is determined to lack sufficient capacity. Capacity should not be conflated with competence.

Competence is a legal term used by lawyers, courts, and healthcare risk managers to indicate that a person has the mental capacity to participate in legal proceedings and stand trial. Adjudicative competence means that someone accused of a crime has sufficient ability and understanding to consult with his lawyer and an understanding of the proceedings against him. Generally, an adult is found to be competent or not without regard to the seriousness of the alleged criminal act. Capacity, on the other hand, can be relative to the risk of the decision being made and is not necessarily stable over time. When a clinical ethicist says that a patient has sufficient capacity (for consent) it means that it has been determined that the patient currently has the ability to appreciate the risks, benefits, and alternatives to a particular treatment. As the risks and complexities of treatment increase so too must the patient's capacity. Unlike the binary nature of competence, capacity is expressed on a sliding scale that is relative to the risk or the gravity of the choices available. And, capacity may also be fleeting...a patient may have sufficient capacity, lack it, and have it again over a matter of months or even days.

In keeping with the general societal rejection of suicide as a rational act, one question is if any suicidal act is a sufficient reason to revise an opinion concerning a patient's current level of capacity and, therefore, negates, even if temporarily, an existing, valid OOHDNR. However, as evidenced by the Oregon Death with Dignity Act, it is arguable that if a person of sufficient capacity desires suicide, that desire is to be accepted within certain boundaries as a competent decision. If the Death with Dignity Act is to be accepted, then not all acts of self harm can be presumed to be irrational acts. Therefore, for EMS personnel, the setting aside of autonomy cannot be based exclusively upon a simple revision of the medical or legal system's opinion of the patient's capacity after an act of self harm.

Beneficence and the Duty to Care

Beneficence (taking positive steps to help others) pulls against autonomy and the right to refuse care and establishes an obligation by a caregiver to protect and preserve life (Beauchamp & Childress, 2001). The principle of beneficence can be placed at risk when a pre-hospital caregiver chooses to provide little more than comfort care to a victim of suicide and a valid OOHDNR is in evidence. In keeping with both this principle and the core values of EMS, there appears to be little doubt that typically in response to an attempt at suicide that an affirmative or even coercive intervention, if necessary, is expected of paramedics. In the field, EMS personnel devote little time to considering the suicide victim's negative right to refuse care or if their patient's decision to end his or her life is autonomous (Sine & Northcutt, 2009). When responding to a suicide, patient autonomy, if given any consideration at all, is quickly set aside by EMS personnel and efforts are immediately undertaken to rescue the patient. Under these circumstances, a patient's consent to treatment, even if explicitly refused by the patient, is presumed to be granted by the emergency service healthcare provider. These paternalistic

actions, taken to benefit the patient without regard to his or her wishes, is justified by a goal of preventing harm to the patient (Childress, 1982). Further, paramedics may take actions that imply that the patient is either not competent (lacks sufficient capacity) or is a danger to himself or herself and possibly others. The paramedic may initiate both patient restraint and detention for purposes of accessing a psychiatric evaluation by other medical professionals as both the medical system and the courts consider the implications of what is often viewed a patient's irrational act.

The reluctance of pre-hospital EMS health care workers to honor a valid OOHDNR if there is an act of suicide may be rooted in beneficence, but may also be influenced in part by who has activated the EMS system. The originator of a call to 911 is often not known to EMS front line personnel. The EMS provider responding to a call to 911 is, therefore, still burdened with the following ethical conundrum: what if the victim, after initiating an act of suicide, has simply changed his or her mind? If it was the patient who has called 911 for assistance, it could be assumed by EMS that the OOHDNR has been partly or wholly revoked and the caller is requesting aid. If the patient is conscious the patient's desires may be determined; however, if the patient is no longer conscious or unable to communicate his or her desires the paramedics are once again left without clear guidance as to the true intent of the call to 911. Changing one's mind after initiating a suicide attempt is not unusual and neither is treatment of a patient who has attempted suicide and then engaged EMS: 58% of Oregon emergency physicians report that they have treated terminally ill patients who have failed in a suicide attempt (Koenig & Salvucci, 1997). Changing one's mind regarding a DNR order is also not unusual. In one study, patient's preferences were not stable over even a short period of two months and patients who initially

opted for a DNR order were more likely to change their minds than those who initially chose CPR (Abramson & et al, 2001).

Conclusion

The call to 911, when a valid OOHDNR is in place, may be made for a variety of reasons. Families may call because they desire medical assistance but also because they did not know what else to do or believed they were required to do so by authorities (Feder & et al, 2006; Muller, 2005; Silveria & et al, 2003). Patients may call because they have changed their mind regarding an end of life decision and an act of self harm. Acute and rapid changes in the patient, the very public view of the care provided, and a need for rapid decision making in a pre-hospital setting make deliberation and reflection regarding the patient's values or true intent a practical impossibility under most circumstances. Typically, following a call to 911, EMS personnel should aid families and the dying by offering appropriate and compassionate care while withholding resuscitation if a valid OOHDNR is in place. However, patient suicides that are concurrent with an OOHDNR do present a very real moral conflict between the two biomedical ethics principles of autonomy and beneficence for EMS providers. Since responding EMS personnel cannot be relied upon to unerringly know if the patient was suffering from a reversible depression with suicidal ideation, has taken an irrational action motivated by fear, or was truly making an autonomous choice for a dignified death, it follows that EMS cannot make judgments regarding either the authenticity or permissibility of any suicidal act (Koenig & Salvucci, 1997). Beneficence, therefore, should be the dominant biomedical ethics principle employed to justify mitigating acts of patient self-harm even if one assumes that personal choice and the right to refuse care is a prima facie right.

Conflicts in many statutory protocols regarding an act of suicide that is concurrent with a valid OOHDNR only serve to further confound how pre-hospital EMS personnel may consistently and properly discharge their duty to both provide care and adhere to core values which are grounded in compassion and advocacy (Sine & Northcutt, 2008). Some jurisdictions have addressed this ethical conundrum by statutorily enabling emergency personnel to paternalistically intervene unless their resuscitative actions would clearly be physiologically futile. This allows EMS personnel to make the least indelible choice regarding resuscitation both ethically and medically. However, until this issue is further resolved at a policy and statutory level paramedics and other pre-hospital care providers summoned by a call to 911 will continue to find themselves in an ethical dilemma regarding resuscitative efforts if a valid OOHDNR is complicated by an act of suicide.

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