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NAVIGATING PRE-HOSPITAL END OF LIFE CARE: A PARAMEDIC PERSPECTIVE

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INTRODUCTION

End of life care (EoLC) issues in the Canadian healthcare system are now commonplace. Palliative care and medical assistance in dying (MAID) programs are giving patients more options than ever before. Consequently, pre-hospital and community paramedicine programs now interact with more patients who require EoLC. This creates ample opportunity for combined growth in the areas of paramedic practice and patient autonomy. This opportunity for growth is not without caveats however. Paramedics now have a responsibility to both further educate themselves and their patients as they increasingly engage with EoLC issues.

DO-NOT-RESUSCITATE ORDERS

A DNR order is a legal document signed by a physician that instructs healthcare professionals to withhold cardiopulmonary resuscitation (CPR) and other advanced life support interventions in the event of cardiopulmonary arrest. They are typically issued to reflect a patient's expressed wish when capable, or in accordance with the wishes of a substitute decision maker (SDM).

Pre-hospital DNR practices vary across Canada, and each province has its own standards. In Ontario, many paramedics would be surprised to know that interpreting a DNR is in fact not part of the paramedic scope of practice. The Do Not Resuscitate Confirmation Form (DNR-CF) is the only legal form which permits paramedics to withhold resuscitative measures in the pre-hospital environment.(1) This form is a single page, bilingual document that is unique to the patient identified by its serial number. It should be noted that the DNR-CF in itself is not a DNR order, merely written confirmation that a legal DNR order does exist.

It is also important to note that the DNR-CF provides a single definition of CPR, defined as "an immediate application of life-saving measures to a person who has suffered a sudden respiratory or cardiorespiratory arrest." Procedures in this definition include chest compressions, defibrillation, artificial ventilation, insertion of an oro/nasopharyngeal airway, endotracheal intubation, transcutaneous pacing and resuscitative drugs such as (but not limited to) vasopressors, antiarrhythmic and opioid antagonists.(1)

CHALLENGES

DNR related conflicts are one of the most frequent dilemmas reported in the pre-hospital setting.(2) The pre-hospital environment is already uniquely challenging as paramedics are tasked with the unimaginable weight of life altering decisions, in small time windows, and with little to no previous information to help guide them.(2) Does our ultimate responsibility lie with our patients, or our duty to care for their families? These situations challenge the very core values of medicine: acting in accordance of what is best for the patient (*Beneficence*) and the principle of do no harm (*Non-Maleficence*).

The Ontario DNR standard does not allow patients to outline pre-consented partial resuscitation wishes. Thus it essentially imposes an all or nothing clause to out-of-hospital resuscitation, which is strictly defined by the definition earlier. This has and will continue to limit patient autonomy as it relates to making decisions about *their* out of hospital resuscitation plan. These standards are a source of conflict between the paramedic's duty to treat and the patient's right to limit resuscitative efforts at the time of death.(3)

Paramedics in Ontario are not required to obtain and confirm an existing DNR.(1)

In fact, if a valid DNR order is presented to paramedics on scene **without** a DNR-CF, the DNR order should be considered invalid, and resuscitative measures should not be withheld until ceased on scene (after a verbal termination of resuscitation order) or ceased in the Emergency Department by a physician. This situation can obviously result in great stress and suffering for family if the patient's final wishes are not followed by paramedics at scene.(4) In situations where there is a complete absence of DNR documentation, a SDM may attempt to verbalize a patient's wishes, leaving paramedics in yet another difficult situation regarding resuscitation attempts.

On the other hand, paramedics may find themselves with a deceased patient who in fact has a valid DNR-CF but a family member voices their disagreement with their loved one's pre-expressed wishes.

In accordance with the Ontario DNR standard, SDMs have the ability to withdraw the DNR altogether at any time, which compels paramedics to resuscitate against their patient's pre-existing wishes. These circumstances are especially difficult for paramedics as they often create an internal moral conflict that must be temporarily silenced for the value of timely professional responsibility. Too frequently are Canadian paramedics subject to these conflicts, which can exacerbate already difficult situations for all parties involved. Policies that allow paramedics to forgo resuscitation attempts based on verbal family requests or the presence of certain clinical characteristics have proven successful in both the US and Canada.(5,6)

ALLOWING NATURAL DEATH

Many healthcare professionals would agree that a significant proportion of out-of-hospital cardiac arrests are in fact natural deaths, and that resuscitation would be likely be futile. Attempts at resuscitation in these cases would entail invasive treatments with little to no benefit and perhaps a considerable amount of harm. This begs an obvious question: why do so many patients lack a clearly defined resuscitation plan? Why are they so reluctant to obtain them?

It is plausible that a significant percentage of people to whom this applies simply do not have the resources to make educated decisions, or perhaps even have the knowledge that they have a choice to make at all.


We should also perhaps consider how a DNR order may influence our everyday practice as paramedics. Should we consider the possibility that a DNR may subconsciously translate to less than optimum care for our patients? As a healthcare community,

the language we use when discussing DNR orders may contribute to the misconception that DNR is synonymous with 'do not treat'. We need to exercise caution when we speak to patients and their families. We know the difference between fluid resuscitation versus cardiopulmonary resuscitation, and defibrillation versus cardioversion, but others may not. To misuse or misunderstand terminology may be detrimental for patients and families when faced with treatment decisions in EoLC issues. Do Not Attempt Resuscitation (DNAR) and Allow Natural Death (AND) orders are variations on EoLC terminology. DNAR orders should explicitly describe the resuscitation interventions to be performed during the resuscitation attempt.(7) AND emphasizes that the order is to allow natural consequences of a disease or injury, and to emphasize ongoing EoLC. Changing our language may lessen the negative connotation around EoLC and DNRs, subsequently assisting patients and families in making appropriate decisions of care that most align with their wishes.

WHAT NEXT?

Do paramedics have a role to play in community based education programs? A role to play in educating our community paramedic clients about different EoLC options? What is the role, if any, for paramedics in MAID? Do we have a role to play in securing legislative change to ensure that we have the information and the tools to make the right decisions for and with patients and their families at the end of life? There are a lot of unanswered questions. However, our greatest responsibility is to relentlessly advocate for the autonomy, respect and well being of our patients in, or after their last moments. Dr. Lisa Caulley perhaps expressed it best when she said "*Medicine is not just about treating illness—it can often involve appreciating the necessity to say no, while allowing patients the dignity to say yes*". (8)

We need to work together to find solutions that will ultimately help to mitigate temporary solutions which are aimed to treat the irreversible reality that is a natural death. Addressing these issues proactively will help alleviate the pressures and uncertainty that so often come with a lack of EoLC direction in the pre-hospital environment.

This article sought to raise these issues in an attempt to start a dialogue among paramedics. Paramedics are trained to resuscitate, but do we have the tools, and are we trained well enough *not to?* 

DISCLAIMER

The views and opinions expressed in this article are those of the authors and do not reflect the official policies or positions of their employers or organizations.

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