



## Dignified death or legislated resuscitation?

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Imagine that you are dying of cancer. Radiation therapy and chemotherapy have failed, and your quality of life is miserable. After consulting your family and your physicians, you decide that, if your condition deteriorates, you do not want to undergo resuscitation. You sign the appropriate papers and set this uncomfortable issue aside, relieved that the decision has been made.

Two weeks later you drift into a stupor and begin breathing erratically. Unsure what to do, your spouse dials 911. Five minutes later, 2 paramedics rush into your house and find you comatose in a recliner. Your skin is grey, you have no pulse, and you take periodic gasping breaths. The heart monitor shows agonal bradycardia. You are moments from death.

One of the paramedics transfers you to the floor and intubates you. The other delivers a precordial thump and begins cardiac compressions. Ribs fracture. Appalled and distraught, your spouse demands that the resuscitation stop. Without looking up, the first paramedic mutters (as kindly as possible under the circumstances) that they are obliged to continue. The other dials up the defibrillator and administers shock treatment. Horrified, your spouse fumbles through a drawer full of papers, looking for the “do not resuscitate” (DNR) document. But even if she found it, it wouldn’t make a difference. At least in Ontario, the decision has been legislated, and your fate is now in someone else’s hands.

Vena Guru and colleagues (page 1251) suggest that this is a common scenario in Canada.<sup>1</sup> In their study of 1534 cardiac arrest calls in Toronto, they found that 144 of the patients had a pre-existing terminal illness and that 90 DNR requests had been made at the scene — most expressed verbally by bystanders. In many of these cases, the paramedics defied the family’s wishes and started resuscitation. It is widely accepted that people have the right to a dignified death, so why don’t the paramedics just back off when it’s clear that resuscitation is inappropriate? They don’t back off because they are in an impossible bind.

Life-saving measures — particularly defibrillation and intubation — must be performed immediately if they are to be effective; therefore, when paramedics arrive at the scene of a cardiac arrest they have only seconds to make a decision. There is no time to ponder comorbidity, quality of life or life expectancy; there is no time to determine whether the people standing in the room are legal guardians or just eager beneficiaries listed in the will; and

there is usually no way to assess the validity of the DNR request. Moreover, there is seldom a graded response to the resuscitation effort. Once it has begun, resuscitation continues until the patient is clearly dead or is stabilized in the nearest emergency department.

This is a serious problem for patients who do not want resuscitation, and it is a problem that must be addressed. Unknowingly, patients and their families trigger the unfortunate sequence of events by dialing 911. They may do so because they are confused about the dying process, because they are ambivalent about the DNR request or because they would like some on-scene medical support and advice. Whatever their reasons, the ultimate irony is that, having made a conscious decision to *refuse* resuscitation, they activate a reflex arc that has one primary outcome — resuscitation!

Physicians who fail to educate their patients (and the patients’ caregivers) are largely at fault. Caregivers of dying patients need to know what to do at the time of death. If the patient’s desire is *not* to be resuscitated, they must be told *not* to dial 911. Yet many physicians fail to broach this topic, and some actually advise family members to “call an ambulance” when death appears imminent.

Perhaps these physicians view paramedics as roving practitioners who will perform a house call, assess the patient’s condition, clarify the appropriateness of DNR, provide comfort during the last minutes of life, counsel the family, facilitate a dignified home death, pronounce the patient dead at the scene and transfer the body to the morgue. But let’s be clear about this. Paramedics do not do house calls and make diagnoses; they are not trained to perform crisis intervention for grieving relatives; and they are not a body removal service. Paramedics are trained in basic and advanced life support. Paramedics resuscitate. Instructions to call 911 are, functionally, a way for physicians to transfer the task of dealing with the dying patient and his or her family to the emergency medical services system.

Guru and colleagues argue for the creation of a DNR protocol for paramedics, one that would allow them to respect established DNR orders in the home. This is appropriate, but it is only part of the solution. Home DNR orders must be written (not verbal), and they must be standardized, dated and signed by the caregiver or a legal advocate. Finally, there should be provision for family support needs that paramedics cannot address.

Programs like this already exist elsewhere in Canada. In British Columbia a standard DNR form is available



throughout the province. It is signed by both the patient (or an advocate) and the physician, and it is valid for 1 year from the date of signing. In addition, the onus is on the physician to provide appropriate counselling and information beyond what is provided on the form. In Vancouver, the Vancouver/Richmond Health Board Home Hospice Program counsels patients and families about end-of-life issues, including how to deal with the actual death. Patients are advised not to call 911, and physicians and home care nurses are on call to provide advice and crisis intervention. Training is available to help family physicians deal with these end-of-life issues.

Of course, families and caregivers sometimes call 911 despite instructions to the contrary. In such cases, the policy of the British Columbia Ambulance Service is to honour a valid DNR form. In the absence of such a form, resuscitation is initiated but can be terminated in the field after discussion with the patient's physician.

More and more patients are choosing to spend their final days in the comfort of their own homes and in the company of their families. All areas of the health care system need to adapt to this shift, including emergency medical systems. Legislated resuscitation no longer makes sense.

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Competing interests: None declared.

## Reference

1. Guru V, Verbeek PR, Morrison LJ. Response of paramedics to terminally ill patients with cardiac arrest: an ethical dilemma. *CMAJ* 1999;161(10):1251-4.

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