CPR is rarely successful in patients with pre-existing chronic illness; only 2% of these patients are discharged successfully after resuscitation.1 Nevertheless, many patients are now resuscitated in the hope that other interventions will reverse the inexorable progress of the underlying chronic condition. Families of dying patients often feel that we must do "everything possible," and, for fear of the legal consequences, many physicians believe that they must initiate CPR even if they know that the outlook is hopeless.1 As a result, CPR is no longer considered an elective life-saving procedure for selected patients with acute but reversible conditions but, in the opinion of many, has become the standard of care for many patients dying in a hospital or nursing home.

However, the attitude is shifting. The medical literature contains many excellent articles suggesting standards and an ethical approach to these difficult decisions. Bedell et al reported the resuscitation status of 521 of 528 patients who suffered cardiac arrest at Beth Israel Hospital during a 12-month period.2 Three hundred eighty-nine of these patients (75%) had been designated do not resuscitate (DNR) prior to their death. The DNR group was more likely to be older, to have cancer, and to have an altered mental status. Blackhall reviewed the status of resuscitation, and he argued eloquently against indiscriminate resuscitation.1

In addition, numerous court cases seeking to limit or discontinue treatment have occurred; the hospice movement has grown rapidly; 37 states have passed "living will" legislation; and advocacy groups such as the Hemlock Society and the Society for the Right to Die encourage discussion of these issues. The first malpractice suit charging wrongful resuscitation has been filed in Ohio, and the popular news magazines are publishing thoughtful and comprehensive articles discussing these issues.3 In a recent survey of more than 500 individuals in Boston, 70% of them said they would decide against resuscitation if they were incompetent with a poor prognosis.4 Most of the older literature has dealt with the resuscitation of patients in hospitals. More recently, there has been an emerging discussion of the appropriateness of attempting to resuscitate all patients in the prehospital setting. With the growth of the hospice movement, more patients are choosing to die at home; with the aging of the population, more people are receiving subacute and chronic care in long-term care facilities. Because of these factors, more Americans are dying outside of the hospital.5 At the same time, advances in emergency medicine now permit advanced resuscitation in the field. Because of the acute nature of the illnesses and injuries seen in emergency medicine and the critical need for a rapid response, palliative care has not been emphasized and may be misunderstood by emergency providers. If emergency providers perceive their role only to be life saving, conflicts may arise between emergency medical services (EMS) and the patients they serve. Most jurisdictions have policies similar to Maryland. Specifically, emergency medical providers are required to resuscitate a patient in the field unless clearcut signs of irreversible death, rigor mortis or decapitation, are present.

This conflict is not merely theoretical. In one author's practice during a two-year period, there were five separate cases of inappropriate attempts to resuscitate terminal cancer patients by emergency medical technicians (EMTs) who were called for emergency transport for palliative needs or because of family panic. Two of these patients were in acute respiratory distress that could not be managed at home, one suffered a massive gastrointestinal bleed with which the family could not cope, one collapsed at an outside laboratory, and one patient suffered a nonfatal, self-inflicted gunshot wound. Each of these patients had expressed the desire not to be resuscitated, and the EMTs were notified of this fact and of the terminal condition. Four of the patients were enrolled in a local hospice program. However, resuscitation was initiated against the patient's and physician's wishes because failure to begin CPR would have violated the EMTs' treatment protocols. Clearly, it was then and is now necessary to develop more mutually supportive ways for different specialties to interact.

As a result of these issues, some local EMS jurisdictions have developed policies regarding the application of DNR orders in the field. As early as 1985, Minneapolis6 and Anchorage7 developed policies limiting attempted resuscitation for selected patients with a poor prognosis, and these early attempts were strongly supported.8 Opinions are hardly unanimous, however, and an intense debate continues.9,10 Nevertheless, a recent survey reported that seven states (including Maryland) and the District of Columbia now honor prehospital DNR orders.11 In six of these jurisdictions, the policy is in the form of a statewide protocol; in one state, it is in the form of an opinion of the attorney general; and in the last state, it is in the form of state law. In addition, 13 states allow or encourage the development of local policies. Only five states mandate resuscitation in all cases.12 The remaining jurisdictions have no general policy and do not address local policies. Twenty-three states were reported to be addressing the issue or refining their current policies.13

Thus, while the debate continues in the literature, it appears that the providers are forging ahead and developing their own policies regarding appropriate levels of care to be provided in the field. The American College of Emergency Physicians has...
EHRITORS:

Hospice/EMS Palliative Care Protocol

1. INTRODUCTION
A hospice patient is a person with a terminal illness with a life expectancy of six months or less and who is under the care of a Hospice Program. Hospice care neither hastens nor prolongs death; it allows the dying process to occur naturally while palliating the patient to the highest degree possible. For the hospice patient, life support measures including CPR are inappropriate.

Hospice programs will continue to include educational programs for patients and families that discourage the use of 911 for hospice patients. Occasionally, however, the EMS system is activated for these patients. This leads to a conflict between the prehospital provider's duty to sustain life and the patient's expressed wish to die naturally. The purpose of this document is to provide prehospital personnel with a medical protocol to follow when called to provide care to a clearly identified hospice patient.

2. CRITERIA FOR ACTIVATION OF THE HOSPICE/EMS PALLIATIVE CARE PROTOCOL
The Hospice/EMS Palliative Care Protocol will only be activated when official documentation of hospice status and confirmation of patient identification is available. The protocol does not apply to vehicular crash scenes or mass casualty incidents. In the absence of confirmed documentation and identification, the patient will be cared for according to standard protocols and training.

2.1 DOCUMENTATION
An official, numbered, Hospice Network of Maryland (HNH) Documentation Card must be present. It will contain:
- Patient Name, Age, Sex
- Driver's License Number (if available)
- Social Security Number
- Height, Eye Color, Hair Color, Race
- Next of Kin and Number
- Hospice Program and Number
- Physician Name and Number

2.2 IDENTIFICATION
If the HNH Card is present then independent confirmation that the patient is the person referred to in the HNH Card must also be obtained. Identification may be confirmed by the patient (if conscious) or at least one of the following individuals who is present at the site:
- Doctor, Nurse
- Hospice Program Provider
- Family Member/Care Provider
- OR Personal Knowledge of Prehospital Provider
(The name of the individual identifying the patient must be recorded in the card.)

3. LIMITED PATIENT ASSESSMENT
3.1 Vital Signs
3.2 History of Episode
3.2.1 Identify reason aid was requested.
3.3 Pertinent Medical History
3.3.1 Medical Problems and Conditions
3.3.2 Medications
3.3.3 Allergies

4. SUPPORTIVE CARE FOR SYMPTOM CONTROL
4.1.3 Position for comfort.
4.2 Blending, External
4.2.1 Standard treatment (direct pressure, dressing, diet)
4.2.2 No Mast Treants or IV's
4.3 Fractures: Immobilize is standard fashion.
4.4 Other Pain or Other Symptoms (e.g., nausea, vomiting)
4.4.1 Allow patient, family, or health care providers (other than the prehospital provider) to administer patient's prescribed medications. Such health care providers administering medications will not have to accompany the patient to the hospital.
4.5 Existing IV's: IV lines may be in place and, if so, should be monitored.

5. INAPPROPRIATE CARE FOR A CONFIRMED HOSPICE PATIENT
5.1 Central Monitoring
5.2 Initiation of IV Therapy
5.3 Medications,.e., order
5.4 CPR
5.5 Intubation (END or Endotracheal or Oral Pharyngeal Airway)
5.6 MAST
5.7 Ventilatory Assistance

6. TRANSPORT
6.1 ALS intervention is not required; BLS transport is appropriate as needed.
6.2 Transport to patient's hospice hospital should be considered if feasible and practical.

7. COMMUNICATIONS
No consultation is required, but the receiving hospital should be notified to expect the patient and prepare accordingly.

NOTE: Please place this page in your protocol manual.

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FIGURE. Hospice/EMS protocol.

also discussed these issues and published an excellent position paper regarding DNR guidelines for prehospital providers. In this discussion, we report a cooperative initiative in Maryland to develop a palliative care protocol that applies to all hospice patients throughout the state. We also report the results of a survey of the hospice providers after one year of operation of the protocol.

Maryland has a statewide EMS system that is coordinated by the Maryland Institute for Emergency Medical Services Systems (MIEMSS). In this program, prehospital providers responding to a call for assistance provide basic life support (BLS) and advanced life support (ALS) as determined by treatment protocols. The ALS protocols are developed by MIEMSS with statewide input and are approved by the Maryland Board of Physician Quality Assurance. The protocols mandate responses to defined symptom complexes and provide the most rapid response to life-threatening emergencies.

In Maryland, 37 distinct hospice programs now serve more than 3,000 patients annually, and the number of referrals continues to increase. Most of these hospice programs are affiliated with the Maryland State Hospice Network (MSHN). As early as 1981, preliminary discussions were held between representatives from MSHN and MIEMSS regarding the management of hospice patients by EMS providers. Despite the termial diseases exhibited by hospice patients, true emergencies do occur and require prompt and appropriate responses to palliate discomfort and prevent further disability. The sudden onset of severe respiratory distress, pathologic fractures, uncontrollable pain, or massive bleeding sometimes requires rapid transport to the hospice or support hospital for the comfort of the patient and family. This may require use of EMS for emergency transport, even though resuscitation is neither desired nor appropriate. At other times, and despite counselling by hospital providers and physicians, a family may prepare for the death of a loved one, but the sight and sounds of imminent death are too much to tolerate, and EMS is called in panic. As a result, the wishes of the hospice patient or family and the services available from EMS may conflict. The patient has expressed the wish for palliative care only, but until recently the EMT was required to resuscitate the patient.

During initial discussions, the EMS community expressed their concerns that hospice patients would overuse their services, that EMTs should not participate in the care of hospice patients because they were trained solely to save lives, and that misidentification of a hospice patient might result in legal liabilities. The hospice community argued that hospice patients were deserving of emergency services that are supported by the public and that the EMTs were obligated to provide palliative services in addition to resuscitation. In time, a basic philosophical difference
between the two groups appeared to emerge. EMS representatives felt that not attempting to resuscitate a patient had negative implications—that they were "failing" the patient by withholding something that could and perhaps should be done. Hospice representatives, on the other hand, felt that not resuscitating certain patients was a positive response because it represented delivery of the most appropriate level of care, which was in accord with the patient's wishes.

In 1985, the Maryland legislature approved The Maryland Life-Sustaining Procedures Act. This legislation approved "living wills" and recognized the patient's right to refuse resuscitation and other aggressive interventions. Because the EMT is unable to determine the validity of such an instrument in the field, the legislature excluded prehospital EMS providers from the requirements of the law. However, this exception created a dilemma: it acknowledged that terminal patients have the right to refuse resuscitation, but in an emergency the EMTs had to resuscitate the patient because the complex documents were not applicable in the field.

The MSHN was concerned about these issues and argued against the EMS exclusion. The EMS community felt it was mandatory to protect the EMTs. Eventually, discussions among the authors led to an improved understanding of the needs and problems of both the hospice and EMS communities. A draft protocol was developed and submitted to a new committee of hospice and EMS providers, representatives from MIEMSS and MSHN, an ethicist, and an attorney. The revised protocol was circulated for review and comment by all interested parties and was submitted by MIEMSS to the Maryland Board of Medical Examiners. It was approved on March 17, 1988.

The protocol addresses the problem of identification by requiring a two-step procedure (Figure). The patient or caregiver must first present the hospice identification card to the responding EMT. These cards are numbered sequentially, available only through hospice members of MSHN, and issued when the patient's desires and intent are clearly known by the physician and hospice provider. The identification of the patient is verified by the EMT on site. The identification procedure requires the EMT to review the hospice documentation card. The EMT must then confirm that the card correctly identifies the patient. This confirmation may be given by the patient, a member of the family, caregiver present, by the patient, or personal knowledge of the EMT. The palliative care protocol will be implemented only when identification is thus confirmed. Maryland does not maintain a central registry of all hospice patients; authenticity of the identification card is confirmed by the EMT on site as detailed.

The protocol mandates specific palliative interventions depending on presenting symptoms. After initial palliative treatment, the patient will be transported to the hospice or support hospital. Other emergency calls take priority, and the EMS personnel will transport to the nearest hospital if their services are needed elsewhere. The protocol applies only to patients enrolled in a licensed Maryland hospice and will be activated only if the patient is clearly identified by the procedure described above. If the EMT has any question regarding patient identification or the patient is involved in a mass casualty situation, the standard treatment protocols will apply.

Successful implementation of this protocol depended on the education of EMTs and hospice patients and their families as to what represented a palliative emergency. The MSHN and MIEMSS therefore devoted six months to educational programs for both the hospice and EMS communities. Training for hospice families consists of discussions with hospice providers and the referring physician. Written materials describing the use of the hospice identification card are also provided by the hospice. The training discourages the immediate activation of the EMS system without a call to the hospice program first. When EMS is needed, services are requested by dialing 911 anywhere in the state. There is no separate emergency number for hospice services, as is the case in some states. Special educational sessions were provided to EMTs and hospice providers, and explanatory documents concerning the use of the EMS are provided to all hospice patients at the time the card is issued.

The protocol was activated on January 1, 1989. In 1990, a survey of all hospice providers was conducted to identify problems encountered and determine success of the program during the first year of operation. The survey was mailed to 32 hospice members of MSHN, and complete responses were received from 19 (59%). In all, 2,052 patients were enrolled in the responding programs during the year; 975 of them requested and received a hospice identification card (48%). One thousand five hundred twelve patients died during the year (74% of the total group), and 785 of the patients with a hospice identification card died (80%). Fifty-two percent of the patients who died had a hospice card, but only 32% of those patients who did not die had a card. This suggests that the hospice programs tended to issue cards to those patients who were more likely to die but were not always successful in making this prediction.

One thousand seventy-seven hospice patients (52%) either refused or were not offered an identification card. Reasons for lack of acceptance of the card included the patient not understanding or being illiterate, the patient dying before it could be discussed, the hospice staff being uncomfortable with the discussion, or, most often, the patient or family being in denial, being overwhelmed by the events, or still hoping for a miracle.

The EMS system received calls for only 52 of the 975 patients with an identification card (5%); virtually all of these calls were for transport to the hospice or support hospital because of palliative needs that could not be satisfied at home. Problems identified included five episodes when families or private duty nurses called EMS without first checking

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with the hospice because of panic or fright and in whom EMS services were not actually required, occasional EMTs who were not familiar with the protocol, and difficulties in obtaining the required physician signatures from major medical centers. Respondents specifically noted that the protocol reassured patients and families that their wishes would be respected, relieved patients’ fears of further painful interventions, gave ethical support to the EMTs, assisted the hospice staff in teaching patients and their families, reduced stress for the hospice workers, allowed transfer to acute care institutions for palliative care while maintaining the continuity of care, and prevented unpleasant memories of the death of a loved one.

There have been areas of concern. Some EMTs were concerned regarding the identification process and feared that they would be sued for inappropriately “withholding care.” In early discussions, we therefore considered the use of identification cards that would include a photograph of the patient. The proposal was eventually rejected because it was thought that a photograph would not be reliable because the hospice patient’s physical appearance changes rapidly, the patient’s inspection of his or her own picture in relation to current appearance might be inhumanely painful, it might stigmatize the patient, and it would add unnecessary expense.

Some EMTs felt that hospices would overuse these services and that use of the EMS was inappropriate for dying patients. Clearly, the program does not overtax the Maryland EMS system because the 52 calls in 1989 represent only a tiny fraction of the 376,772 total EMS calls received during the same period. Conversely, some have argued that the palliative care protocol is not necessary because the numbers are so small. However, for those patients who do receive this service, the program is very significant.

Some hospice physicians have objected to the protocol’s exclusion of IV analgesics. To provide for this, however, it would be necessary to use ALS services. It was also thought that because of the excellent palliative care offered by hospice, pain control would rarely present as the sole palliative care emergency. The protocol does allow caregivers present other than the EMT to administer the patient’s routine pain medications by order of the attending physician.

The major objection remains that the protocol is too restrictive because it applies only to patients enrolled in a formal hospice program. Clearly, this is the case because it was developed specifically for hospice patients to resolve the potential conflict between EMS and the hospice under current law in Maryland. We are sympathetic to nonhospice patients who do not desire resuscitation, but in this situation another mechanism for appropriate identification must be developed.

MIEMSS and MSHN are monitoring the use of the protocol, and discussions continue regarding related issues such as DNR patients requiring transportation from chronic care facilities, and management of the nonhospice, terminally ill patient and other patients who do not wish to be resuscitated.

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