R04: Resuscitation Decision-Making

Clinical Medical Programs
Updated:
Reviewed:

Introduction

This guideline has been designed to provide information to paramedics and EMRs on the holistic aspects of cardiac arrest management: specifically, to provide more information regarding resuscitation decision-making and end-of-life care.

Advance Directives, Medical Orders for Scope of Treatment, and No CPR Orders

- What is an advanced directive?
  - An advanced directive is a written instruction made by a capable adult that (a) gives or refuses consent to treatment at the time treatment is required and (b) complies with the requirements of the *Health Care (Consent) and Care Facility (Admission) Act*.
- What makes an advance directive legal?
  - The legal requirements for an advance directive are that it be in writing, be made and signed by the adult at a time when the adult is capable, and be witnessed by two people who may each act as a witness (or one person, if the witness is a lawyer or notary public). Additionally, in the advance directive document, the adult must indicate, in writing, that the adult knows:
    - A health care provider may not provide to the adult any health care for which the adult refuses consent in the advance directive, and
    - A person may not be chosen to make decisions on the adult's behalf for any health care for which the adult has given or refused consent in the advance directive.

Overriding an Advance Directive or Medical Order for Scope of Treatment

A competent patient can *always* make decisions regarding their own care.

- Advance directives allow patients to state their decisions in writing regarding future health care treatments, in the event they are either unable, or not considered competent to communicate them. There are limited situations in which advance directives may be overridden. (For example, there may have been significant changes in medical knowledge, practice, or technology since the directive was written.)
- Medical orders for scope of treatment (MOST) are developed as part of a conversation between a physician (or, in some cases, a nurse practitioner) and the patient, or the patient's substitute decision-maker. A MOST is required to be reviewed regularly by the physician and, unless there has been a substantive change, cannot typically be overridden by a substitute decision-maker.
- An advance directive or MOST should not be overridden without appropriate consultation and direction. In this, or any situation where paramedics or EMRs are uncertain about the appropriateness of a particular clinical intervention, or whether or not to start CPR, CliniCall (1-833-829-4099) should be contacted for support.
- MOST forms are not standardized across health authorities. Paramedics and EMRs should familiarize themselves with local forms here.

Temporary Substitute Decision-Makers

A temporary substitute decision-maker is a capable adult over 19 who has been chosen *by a health care provider* to give or withhold consent on behalf of another adult, when that adult is incapable of making decisions about their own health care.

In the *Health Care (Consent) and Care Facility (Admissions) Act*, a health care provider is defined as a professional licensed, certified, or registered to provide health care in British Columbia under either the *Health Professions Act* or the *Social Workers Act*. Paramedics and EMRs are not currently listed in either act, and therefore are unable to appoint a

temporary substitute decision-maker to assist in clinical decision-making. Paramedics and EMRs may, however, use the services of a substitute decision-maker should one be appointed by an eligible health care provider (including a family physician or EPOS physician).

Conflicting Information

In the unlikely event that an advance directive and a MOST or No CPR form offer conflicting information, paramedics and EMRs should recall that Section 11 of the *Emergency Health Services Act* prohibits medical care if an advance directive refuses permission to provide such care.

Additional Resources

For more information please access *BCEHS Policy* and *BCEHS Procedure.*

Documentation Requirements

The following information must be recorded in the electronic patient care record:

1. If the decision to discontinue or withhold resuscitation was made by the *paramedic* or *EMR* in accordance with the discontinuation criteria (as established in → R02: Discontinuing Resuscitation), the record must include:
    1. The identity of the paramedic or EMR making the decision, and
    2. The clinical circumstances and findings that enabled the decision to withhold or withdraw interventions in accordance with the requirements listed in → R02: Discontinuing Resuscitation
2. If the decision to discontinue or withhold resuscitation was made by a *health professional*, the record must include:
    1. The identity, unique identifier, and contact details of the practitioner making the decision, and
    2. The clinical circumstances supporting the decision to withhold or withdraw interventions on the basis of good medical practice.
3. If the decision is made on the basis of *the patient's decisions* (either in writing, or in the form of documentation), the record must include:
    1. The type of legal documentation providing consent to withhold or withdraw resuscitation.
    2. The direction, as outlined in the documentation.
    3. A good quality photograph of all pages of the document, taken in such a way that it is materially similar to the original document.
    4. Details of the clinical assessment that would demonstrate that the direction applied in the current circumstances.

No Clinical Procedures are to be Performed Following the Recognition of Life Extinct

Once it is determined that life is extinct, all resuscitation activities must immediately stop. It is unacceptable to continue resuscitation, perform invasive procedures, or implement any form of treatment if the intent is to allow paramedics or EMRs the opportunity to acquire or maintain clinical competencies.

References

1. Grunau B, et al. Comparing the prognosis of those with initial shockable and non-shockable rhythms with increasing durations of CPR: Informing minimum durations of resuscitation. 2016. [Link]
2. Grunau B, et al. Gains of continuing resuscitation in refractory out-of-hospital cardiac arrest: A model-based analysis to identify deaths due to intra-arrest prognostication. 2017. [Link]
3. Grunau B, et al. External validation of the universal termination of resuscitation rule for out-of-hospital cardiac

arrest in British Columbia. 2017. [Link]

4. Morrison LJ, et al. Validation of a rule for termination of resuscitation in out-of-hospital cardiac arrest. 2006. [Link]
5. Reynolds JC, et al. Association between duration of resuscitation and favorable outcome after out-of-hospital cardiac arrest: implications for prolonging or terminating resuscitation. 2016. [Link]