

**Florida  
End-of-Life Care  
For the Emergency Medical Services Provider**

**Instructor's Guide**

Developed by the  
EMS Advisory Council Ad Hoc Committee  
For End-of-Life Care

Supported by the  
Florida Partnership for End-of-Life Care

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## Table of Contents

Slide Titles .....	3
Pre-test .....	5
Slide Notes .....	6
Introduction to End-of-Life Care in the Pre-Hospital Environment .....	6
Credits .....	7
Course Objectives .....	8
Course Outline .....	8
Fundamental Truths .....	10
Facts and Statistics .....	11
Identifying the Myths .....	13
Attitudes and Perceptions .....	14
Personal Feelings on Death .....	16
Stages of Grief .....	17
Normal Physical Signs and Symptoms with Appropriate Responses .....	18
Why Call 9-1-1? .....	20
Cultural Competency .....	21
Communication .....	23
Facing Death on the Job .....	24
Patient Autonomy .....	25
Advance Directives .....	26
Living Will v. DNRO .....	28
Do-Not-Resuscitate Order .....	29
Legal Authority .....	30
Do Not Resuscitate Order Form 1896 .....	31
DNRO Patient Identification Device .....	32
Frequently-Asked DNRO Questions .....	33
Discussion/Practice Scenarios .....	36
Post-Course Assessment .....	37
End-of-Life-Care Course Evaluation .....	39

## Slide Titles

<b>Slide Number</b>	<b>Content</b>
1	End-of-Life Care for EMS Providers
2	Credits
3	Course Objectives
4	Course Objectives, continued
5	Course Objectives, continued
6	Fundamental Truths
7	Fundamental Truths
8	Fundamental Truths
9	Fundamental Truths
10	Facts and Statistics
11	Facts and Statistics, continued
12	Identifying Myths
13	Death – Attitudes and Perceptions
14	Death – Attitudes and Perceptions, continued
15	Personal Feelings on Death
16	Personal Feelings on Death, continued
17	Stages of Grief Process
18	The Dying Patient
19	Normal Emotional, Spiritual, and Mental Signs
20	Why do they call 9-1-1?
21	Cultural Competency
22	Non-Verbal Communication Across Cultures
23	Facing Death at Work
24	Patient Autonomy Issues
25	Advance Directives
26	Living Will v. DNRO
27	Do-Not-Resuscitate Order in Florida
28	Legal Authority
29	Legal Authority, continued
30	DNRO Form 1896
31	DNRO Form 1896
32	Patient Identification Device
33	Frequently Asked DNRO Questions
34	Frequently Asked DNRO Questions
35	Case Presentations
36	Case 1
37	Discussion
38	Case 2
39	Discussion
40	Case 3
41	Discussion

## End-of-Life Care for the Emergency Medical Services Provider

<b>Slide Number</b>	<b>Content</b>
42	Case 4
43	Discussion
44	Questions

## Pre-test

Circle the answer to each of the following questions as either "true" or "false."

1.    True      False      Only an original DNRO form may be accepted to terminate resuscitative efforts.
2.    True      False      If 9-1-1 is called; resuscitation is required even in the presence of a valid DNRO.
3.    True      False      An EMS system's local medical protocol can elect to accept photocopies of a patient's original DNRO form not on yellow paper.
4.    True      False      The EMT or paramedic should allow a person to work through their grief process and empathize with the person.
5.    True      False      EMS is required by law to honor either a DNRO or living will.
6.    True      False      A valid DNRO may be revoked by any family member.
7.    True      False      Supportive care should always be provided to a patient with a valid DNRO.
8.    True      False      By law, a DNRO can be written for a patient with a terminal condition.
9.    True      False      A DNRO order does not have to be signed by a physician.
10.   True      False      It is necessary to verify patient identity when presented a valid DNRO.

## Slide Notes

### Slide 1

#### **Introduction to End-of-Life Care in the Pre-Hospital Environment**

The Florida Partnership for End-of-Life Care is a collaboration of public and private organizations committed to ensuring appropriate end-of-life care and education for Floridians through the coordination and communication of the efforts of all organizations, agencies, coalitions, and individuals interested in Florida's end-of-life issues. The Florida Department of Health is one of the founding members of the partnership and, as part of this Robert Wood Johnson Foundation grant, has agreed to explore the design and implementation of end-of-life training with emergency medical services (EMS) personnel. The goal of this training is to ensure that EMS professionals have the necessary knowledge to promote the highest quality of medically appropriate care while protecting the rights of the patient at the end-of-life.

Attention to care at the end-of-life has become a priority to EMS providers as medical technology and mobile treatments advance to include high standards of care, including cardiopulmonary resuscitation and advanced cardiac life support. For the terminally ill patient, or the patient's family, some medical treatments are futile and obtrusive. These patients, and their families, have searched for ways to honor the patient's wishes to withhold life-sustaining measures in any setting.

The State of Florida responded, as have many other states, by creating a form to be used in the pre-hospital environment. The first Do-Not-Resuscitate Order (DNRO) was incorporated into Florida Administrative Code in 1992, evolving over the years to the current Department of Health Form 1896, sometimes recognized as the "yellow form".

The form was intended to maintain the balance between honoring the patient's right to make his or her own healthcare decisions and the provider's right to immunity for honoring those choices. An Ad Hoc Committee was created from the Emergency Medical Services State Advisory Council to address how to better prepare EMS workers in the field to better maintain this balance, while providing appropriate care that allowed for the withholding or withdrawal of resuscitative measures.

**Slide 2**

**Credits**

The Ad Hoc Committee Members, who have met over the last 18 months to design and implement this curriculum, include:

- Ms. Christine Argo, Department of Health
- Ms. Britt Bullard, R.N., Community Hospice of Northeast Florida, Inc.
- Mr. Bobby Hall, Fire Rescue Chief, St. Johns County Fire Rescue
- Mr. Paul Madden, Department Chair, EMS/Fire, Sarasota County Technical Institute
- Mr. Robert Marschall, Training Officer, Hillsborough County Fire Rescue
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- Ms. Jessica Swanson, Department of Health
- Dr. Linda Swisher, Program Director for Health/Fire Science, Sarasota County Technical Institute
- Dr. Robert Tober, M.D., F.A.C.E.P., Chairman, Department of Emergency and Ambulatory Medicine, MCH Healthcare System, Medical Director, Collier County EMS
- Ms. Freida Travis, Department of Health
- Mr. Ricky Webb, Lieutenant/Paramedic Seminole County EMS/Fire/Rescue

The committee would like to offer a special thank you to our providers who reviewed or pilot tested this curriculum and provided feedback to improve end-of-life care in the State of Florida.

- Alachua Department of Fire/Rescue Services
- City of Seminole Fire Rescue Department
- Longboat Key Fire Rescue
- Manatee County Government Public Safety Department
- Miami-Dade Fire Rescue
- Nassau County Fire Rescue
- Palm Beach Community College
- Palm Beach Fire Rescue
- Pinellas County EMS and Fire Administration
- Sarasota County Emergency Services
- Seminole Community College
- St. Lucie County Fire District
- St. Petersburg College
- West Palm Beach Fire Rescue

Special thanks to Jeanne Kerwin and the Atlantic Health System, Overlook Hospital for access to their “Medical Ethics in EMS for New Jersey” course materials.

**Slides 3, 4, and 5**

**Course Objectives**

- Discuss the unique pathophysiology of the patient at the end-of-life.
- Define and discuss the stages of grief, and reactions to death and dying as defined by Kubler-Ross.
- Discuss cultural competency issues related to death and dying.
- Discuss the reaction(s) to death by the pre-hospital healthcare provider.
- Discuss the history of “End-of-Life” orders and documentation in the State of Florida.
- Define and discuss specific Florida statutes and rules pertaining to end-of-life care, including Chapter 401.45, Florida Statutes, Chapter 765, Florida Statutes and Chapter 64E-2.031, Florida Administrative Code.
- Review and discuss a valid DNRO form 1896 and patient identification device.
- Discuss the specific differences and legal implications between a “living will” and a DNRO.
- Define the role of the designated health care surrogate, court-appointed guardian, proxy and durable power of attorney.
- Discuss supportive and comfort care management plans for the patient with a DNRO.
- Define and discuss local protocol for enforcing a DNRO at the time of a patient’s death.
- Identify cultural reactions related to death and dying.
- Demonstrate effective communication strategies for interacting with the patient and family.

**Course Outline**

**Pre-test**

**Introduction**

**Course Goals and Objectives**

**Topics**

- Population statistics, epidemiology, social aspects etc.
- Kubler-Ross – stages of the grief process as it relates to death and dying.
- Cultural issues related to death and the grieving process.
- Impact on the pre-hospital healthcare provider.

## End-of-Life Care for the Emergency Medical Services Provider

- Supportive and comfort care management plans.
- Legislation related to the State of Florida DNRO.
- The DNRO form 1896 and ID device.
- Healthcare surrogates, court-appointed guardians, proxies, durable power of attorney for healthcare.

### **Protocol and Procedure**

- Procedures for situations involving an invalid DNRO.

### **Scenarios**

### **Resources**

### **Post-Course Assessment**

### **Course evaluation**

**Slides 6, 7, 8, and 9**

**Fundamental Truths**

There are several “fundamental” truths intrinsic to not only EMS providers, but to people in general.

*Everyone dies.* Whether it is easy to admit or not, it is true. You, too, will someday bite the dust, kick the bucket, or buy the farm. It is inevitable and unavoidable.

*Everyone has the right to make decisions about his or her health care.* The decision may be to not decide, or to wait it out. Whatever the choice, it may make the process of life and death a little more pleasant or at least more tolerable. Particularly when a person is facing decisions at the end-of-life, the choice to medicate, treat, or tolerate pain becomes more significant.

*You will encounter death and dying in your profession.* This is particularly true of EMS providers, but it affects everyone. From the co-worker who loses a son, a mother or a husband to actually being on scene, the ability to save a life or let one go will touch you.

*Everyone reacts to death.* From the way you handle that co-worker to your ability to grieve and respond to suffering, you will react. Some reactions may include denial or thinking that you are immune to it, but you cannot be exposed to death without reacting to it in some way.

**Slides 10 and 11**

**Facts and Statistics**

Florida Statistics:

- 4<sup>th</sup> in population
  - Diverse race/ethnicity, urban/rural populations, religions and cultures
- Highest percentage of elderly population
- Deaths
  - 50% in hospitals
  - 25% in a residence
  - 20% in nursing home care
  - 5% in other settings
- Heart disease is the number one cause of death – almost one in every three.
- Cancer is the second leading cause of death – almost one in every 4.
- Heart disease and chronic obstructive respiratory disease – the fourth highest death rate in the country.
- HIV/AIDS – the 3rd leading cause of death among in persons 25-34 years of age.
- 101 Florida physicians are certified by the American Academy of Hospice and Palliative Medicine.
- All hospice patients and approximately 50% of nursing home residents have advance directives, versus 18% of Florida’s overall population.

Source: Statistics for 2001. Florida Department of Health, Office of Vital Statistics

**NOTE:** These statistics show it is important to address end-of-life issues and concerns in Florida. With a large elderly population living both at home and in nursing homes, it is vital that we explore how people want to die and how to accommodate this process.

As Florida’s population grows, so do instances of HIV/AIDS and other terminal illnesses, indicating that it is not just those over 65 who are dying. A difficult concept to address, but necessary, is the fact that there are young people who die every day. Many die from accidents and terrible traumas, but some die from lingering disease and illness. When discussing end-of-life policies, there must be considerations for minors, and how their end-of-life choices may or may not be different from those of an elder person.

## End-of-Life Care for the Emergency Medical Services Provider

Also important to the discussion of end-of-life care is the diverse ethnic and cultural population in Florida. Ranging from Haitian to American Eskimo, this diversity creates the need to pay attention to cultural competency issues. How do different people approach death? This also must be considered in how we care for people and make decisions for them at the end of life.

Slide 12

## Identifying the Myths

There are several ways people view the dying experience and probably hundreds, if not thousands, of ideas on what happens after we die. There is no way to prove or show what actually occurs, but we can discuss the process of death and some of the myths surrounding the grieving process.

The process of grief includes accepting the reality of loss, feeling the pain of grief, adjusting to a new environment and reinvesting emotional energy in new relationships. The range of physical and emotional response varies from person to person, but can effect things like dress, social activities, work performance, and even drug and alcohol intake.

Several misconceptions or myths that surround the grieving process include:

- Grief and mourning are the same experience.  
Mourning is the cultural response to grief, while grief is the emotional reaction to the perception of loss. Grief is a continuing and natural process that can take on many stages and forms.
- There is a predictable and orderly stage-like progression to the experience of mourning.  
Grief follows its own order and is constantly changing.
- It is best to move away from grief instead of toward it.  
Accepting the reality and feeling the pain are ways to work toward assimilating the loss into your life. Denying these feelings can lead to greater trouble and anguish later.
- Following the death of someone significant to you, the goal is to “get over” your grief.  
Grief over someone close to you is something you assimilate into your life. You will never be “over” the loss of a loved one.
- Tears expressing grief are only a sign of weakness.  
Tears are one way to express the pain of a loss, and are a healthy and normal reaction to grief.

Source: Community Hospice of Northeast Florida, Inc., Volunteer Training Information, 2000

Slides 13 and 14

## Attitudes and Perceptions

A difficult barrier to break in emergency medicine is that sometimes caring can go further than curing, especially with a terminally-ill patient. It is difficult for many in this career to deal with someone at the end-of-life, because it often requires forgoing traditional means of caring or treating, such as CPR, for more medically-appropriate care that may involve “letting” or watching someone die.

Before we discuss death on the job and the protocol of allowing someone to die, it is important to get in touch with our own attitudes, perceptions, and personal feelings about death. This is a personal issue, and may be tough for some people to do “out loud” or in public. It is important to your work for you to consider your views on death because it will shape the way you handle death in the field.

Start with a few thought-provoking questions.

- What are your experiences with death?  
A traumatic death of a loved one or patient? A long-term illness and expected death? Someone passing peacefully in his/her sleep?
- At what age were you aware of it?  
Under three? Three to five? Under ten? Older than ten?
- What was your first experience with it?  
A family member? A friend or acquaintance? A public figure? A patient? A pet?
- Did your family discuss it?  
Openly? With discomfort? As if it were taboo? Not at all?
- What influenced your attitude towards it?  
Religion? Work? T.V. or movies? Family attitudes? Introspection and meditation? Attending funerals/wakes? Death of someone close to you?
- Did religion play a role?  
Are there aspects of your religion that helped ease some of the sadness and pain of death? Did the belief in an afterlife help to explain what happens after death? Did you question your religion after someone close to you died?
- What do you believe happens after death?  
Reincarnation? Heaven/Hell? Nothing?
- Are mourning and grief rituals important to survivors?  
What purpose do they serve? Do they offer relief? Do they help with closure?
- How do you feel when you see a dead body?  
Angry? Grossed out? Disappointed? Scared?

## End-of-Life Care for the Emergency Medical Services Provider

- How do you feel when you think about death?  
It is the end? It's a transition? Don't know?
- What is the proper response to keeping a seriously ill person alive?  
By any means necessary? Reasonable efforts? Should a dying person be kept alive by any artificial means? A merciful death?

**Slides 15 and 16**

**Personal Feelings on Death**

After thinking about your attitudes and perceptions regarding death, begin to address your personal feelings on death. Not just people you may have known, but your own death. Ask yourself some questions:

- Have you thought about your own death?  
Never? Once in a while? Frequently?
- What is unpleasant about it? What is troubling?  
No more experiences? Leaving family/friends behind? It might be painful?
- If you had a terminal illness, how would you want to be treated?  
Would you talk about it? Would you want to be told?
- What illness is most distressing to you?  
Cancer? Alzheimer's? AIDS? Why?
- Would you like to know the exact date of your death?
- If you had limited time to live, what would you do?  
Nothing? Make significant changes? Shift your needs to others? Complete projects?
- Have you made your own funeral arrangements?
- Have you thought about a will? A living will?
- How have these questions made you feel?  
Anxious? Revealed areas to explore? Realized mortality?

Slide 17

## Stages of Grief

Now that you have thought about the emotional side of death and dying, there is some information you can learn about the grieving process and the process of death.

Grief is the emotional reaction to the perception of loss, which may be continually changing. It is natural and it can exhibit itself in several ways. Mourning is the cultural response to grief and may be socially influenced. Bereavement is simply the state of having suffered a loss.

There are five common characteristics of grief and bereavement important for you to be aware of as you work in the field and for your own personal information. Grief does not follow an orderly process, and the characteristics do not come in any particular manner. The *emotions* common to grief are:

- **Denial** – The death didn't happen; it can't be true. Denial can help absorb the shock of what happened.
- **Fear** – A response to the unknown. Can increase isolation and panic.
- **Anger** – Stems from a sense of unfairness and can be directed in many ways. Can give an energy release, and if not expressed can turn into depression.
- **Depression** – Need to withdraw and withhold.
- **Bargaining** – Willingness to offer anything, at any cost, in return for life. Move towards acceptance and self-evaluation.

These emotions are part of Elizabeth Kubler Ross' theory on the five stages of the grief process, which are:

- **Stage One:** Denial and Isolation
- **Stage Two:** Anger
- **Stage Three:** Bargaining
- **Stage Four:** Depression
- **Stage Five:** Acceptance

**Slides 18 and 19**

**Normal Physical Signs and Symptoms with Appropriate Responses**

There are several signs and symptoms that are associated with the end of life. They are important to recognize and understand in order to help treat and comfort family members.

- Fluid and food decrease as the body begins to shut down. This is a normal response to conserve energy. Food and drink should not be forced because it can make the person uncomfortable.
- Urine decreases as the fluid intake decreases and less fluid is pumped through the kidneys. There may be cause to insert a catheter if the person is uncomfortable.
- The person may lose control of bowel and/or bladder movements as muscles relax. It is necessary to keep the person dry and clean.
- The person may spend more time asleep and appear unresponsive due to the slow-down in metabolism, which is normal. Generally, touch and hearing stay intact until the end.
- The person at the end of life may appear restless and repeat motions, because the brain slows due to a decrease in oxygen. It is not necessary to restrain or try to control this activity, but to soothe, with medication if necessary.
- The person may experience some disorientation or be confused about people, time and/or place, due to physical changes in the body. It helps to speak softly, clearly, and to identify yourself and your reasons for doing things. It is not appropriate to manipulate or deceive to meet your needs.
- Occasionally, due to changes in the body, a person may be suspicious or reject medicines, fluid, or care. Do not attempt to force or restrain the person. Contact a healthcare provider or hospice representative to address these issues.
- The person may experience some fever due to bodily changes. This may be treated with sponge baths or medication.

## End-of-Life Care for the Emergency Medical Services Provider

- The person may have increased congestion due to changes in fluid intake and the inability to cough up normal secretions. Suctioning may be used, but can be uncomfortable and ineffective. Turning the head and allowing gravity to drain may be more useful. Wiping the mouth and nose may also help. This does not signify patient discomfort or the need for advanced treatment, but may be a concern to family and friends.
- The person's extremities may feel cool to the touch and may change color slightly due to decreased circulation and can be helped with light blankets or coverings.
- The normal, regular breathing pattern may change either by speeding up or slowing down, called "Cheyne-Stokes Respiration." There is no need to treat or to try to regulate breathing, because this pattern is a common part of the dying process. Comforting the patient and light massage are appropriate at this time.
- Other emotional, spiritual, and mental signs at the end of life include withdrawal, vision-like experiences, restlessness, and decreased socialization. These signs can be addressed in many ways depending on the culture and religion of the person. Allowing someone to release fears and tensions, or giving permission for the person to go may help them as they work through this difficult time.

Source: "Preparing for the Dying Experience, Life's Changing Journey," Community Hospice of Northeast Florida, Inc. Pamphlet

Slide 20

## Why Call 9-1-1?

There may be a number of reasons why a family or healthcare provider may call 9-1-1, even if the person has a valid DNRO and wishes not to be resuscitated. Some healthcare providers call to protect themselves from liability. Having addressed some of the physical signs and symptoms of death, it is easy to understand how a family member or even a caregiver may need additional assistance. Even families enrolled in hospice care may call 9-1-1 to help manage the death of their loved one.

The important thing to remember is that a call to 9-1-1 is a call to treat the patient or to help the patient's family, even if that means allowing the patient to die. A family or caregiver's call should be met with the same attention and level of care that any other call would receive. **A DNRO does not mean Do Not Treat.** Comfort care measures can still be administered; they may need treatment of a GI bleed, bowel obstruction or some other reversible condition. The family may decide to transport the patient to help keep him or her comfortable.

The importance of educating EMS providers on the dying process and their role is vital. EMS is a service for the dying patient, and knowing how to recognize the signs and symptoms of death and communicate with the family is an important role. It is important that EMS providers handle a patient at the end of life with compassion, respect, and appropriate measures.

Slide 21

## Cultural Competency

With a diverse population in Florida, it is important to recognize the need to respect diverse healing views, philosophies, and beliefs about dying and death practices.

There are many varying ethnic and cultural views on the dying process and how the body should be handled. It is necessary for you to understand that there are varying viewpoints, and to be appropriate in honoring a patient's last wishes and values. It is not necessary to know each cultural practice, just to be aware that there are many differences, and to respect the family's wishes.

There are also non-verbal communication barriers across cultures, such as touching, eye contact and distance between people, gestures, and the volume of the voice. It is not expected that an EMS provider memorize each culture's preferences, but it is necessary to have an understanding, awareness, and respect for what is happening around you as you deal with end-of-life issues.

Examples of cultural death and dying practices:

<b>Egypt</b>	Family may want to keep diagnosis a secret. Use of amulets with verses of Koran. Charms of hand with five fingers to ward off evil eye.
<b>France and/or Greece</b>	Elderly woman or relative may wash body with water or wine. Ritual is not completed until the body is exhumed 5 years after death and placed in an urn or vault. Widow wears dark clothes for life.
<b>Haiti</b>	Grief is not expressed until possessions have been removed from the home. Burial within 24 hours. No embalming. Grievors may assume symptoms of patient's last illness. White clothing represents death.
<b>India</b>	Family may prefer that non-Hindus not touch the body and wash it themselves. Nodding of the head for yes and no are opposite with those of the U.S.

## End-of-Life Care for the Emergency Medical Services Provider

<b>Cambodia</b>	Coining is practiced – the rubbing of a heated or oiled coin on the body to give relief. Wrist strings are worn to prevent soul loss.
<b>China</b>	Aversion to death and anything concerning it. Eldest son makes arrangements for deceased. White is worn as a sign of mourning.
<b>Thailand</b>	Placing a pillow or any cloth that had rested near or on the lower body at or near the head is unacceptable.

Source: "Bridging the Cross Cultural Gap" Kathleen Premdas, *Nursing* February, 1996

**Slide 22**

**Communication**

Understandably, there is a degree of discomfort once a person has died. The EMS provider is left to communicate with the family until additional support arrives or until his or her job is completed on scene. Communication, especially listening, is a key factor in medically appropriate care at the end of life.

Listening includes:

- Speaking clearly and accurately
- Accepting reactions (remember it can range from anger, fear, bargaining, depression, and denial)
- Not attempting to tell the person how he or she feels
- Not probing
- Comforting children. Do not assume they do not feel or know what has happened
- Avoiding conversations with others (co-workers) about trivial things in the presence of the recently bereaved (e.g., work, the stock market, sports, etc)
- Allowing the person to “work through” grief
- Empathizing, but not saying you understand how they feel (i.e., “This must be difficult for you”, not “I know how you feel, when my Aunt Mary died, I was torn up for weeks...”)

Other communication tools to remember are:

1. Avoid clichés and easy answers
2. Be yourself
3. Accept silence
4. Be a good listener
5. Look for a quiet place to talk
6. Try to have resources for the person

Remember that in your role as an EMS provider, you are a facilitator for the family and caregivers at this moment. You should be able to answer questions, observe details, listen compassionately, and provide some type of closure when you leave.

**Slide 23**

**Facing Death on the Job**

- CPR
  - Reasons to withhold
    - Obvious death
    - Rigor Mortis
    - Decapitation
    - Tissue decomposition
    - Legal reasons-competent refusal or written directive.
  - Moral judgment v. legal obligation

The American Heart Association and American Academy of Sciences have published recommended guidelines on when to initiate CPR based on the percentages of successful outcomes. CPR is intended for patients with a reversible response to a treatable condition, not for people in an end-stage condition or with a terminal disease. Please consult with your local protocols or medical director to establish appropriate and humane policies regarding the resuscitation of patients.

- Insert local protocols – when to call medical director, under what circumstances, other responsibilities
- Insert local protocols – when to terminate CPR/Resuscitative measures besides presentation of a legal DNRO.

Source: "Death Blows". Obel, J. (2002). *Washington Post*, April 2, 2002.

**Slide 24**

**Patient Autonomy**

All persons deserve respect for their wishes, regardless of whether or not we agree with them. This is a difficult concept for many healthcare providers, as medical care is directed to help heal and to save lives. A person's autonomy covers topics beyond healthcare issues, but for the person at the end of life, the ability to determine his or her own medical care offers control.

Respect for one's medical wishes must coincide with the ability to legally honor those wishes and must be done within the context of what is responsible, legal action. Any healthcare provider has the duty to act in the best interest of his or her patient. This does not mean that what the healthcare provider feels is best, but what is in the best interest of the individual being treated.

An EMS provider responding to an end-of-life call must balance the best interest and wishes of the patient with a legal responsibility to act or to withhold care.

Many EMS providers can probably recall a time when they have had to make a judgment on the type of care to render to a patient; some even may have had to make a decision on resuscitation. Not until a decade ago did legal forms exist to withhold or withdraw life-sustaining measures.

It is important that as healthcare providers, each of us take the time to understand our own moral beliefs and how we integrate those into our work. It is also essential to understand local and state laws so that we do not become fearful of legal repercussions when honoring a legal medical request.

Slide 25

## Advance Directives

There are several types of advance directives a person may decide to complete as defined by Chapter 765, Florida Statutes.

**Advance Directive** – pursuant to section 765.101(1), Florida Statutes, is a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's healthcare, and includes, but is not limited to, the designation of a healthcare surrogate, a living will, or an anatomical gift made pursuant to part X of Chapter 732, Florida Statutes.

**Living Will** – pursuant to section 765.101(11), Florida Statutes, is a witnessed document in writing, voluntarily executed by the principal in accordance with section 765.302, Florida Statutes, or a witnessed oral statement made by the principal expressing the principal's instructions concerning life-prolonging procedures.

**Designated Healthcare Surrogate** – pursuant to section 765.101(16), Florida Statutes, is any competent adult expressly designated by a principal to make healthcare decisions on behalf of the principal upon the principal's incapacity.

**Court-appointed Guardian** – pursuant to section 744.312, Florida Statutes, is an individual, who is at least 18-years-old, and who is deemed fit, proper and qualified to act as guardian, whether related to the ward or not. Before a judge appoints an individual as guardian, the individual undergoes considerations noted in section 744.312, Florida Statutes.

**Proxy** – pursuant to section 765.101(15), Florida Statutes, is a competent adult who has not been expressly designated to make health care decisions for a particular incapacitated individual, but who nevertheless is authorized pursuant to section 765.401, Florida Statutes, to make healthcare decisions for such individual.

**Durable Power of Attorney** – pursuant to section 709.08(1), Florida Statutes, is a written power of attorney by which a principal designates another as the principal's attorney in fact. The durable power of attorney must be in writing, must be executed with the same formalities required for the conveyance of real property by Florida law, and must contain the words: "This durable power of attorney is not affected by subsequent incapacity of the principal except as provided in section [709.08](#), Florida Statutes"; or similar words that show the principal's intent that the authority conferred is exercisable notwithstanding the principal's

## End-of-Life Care for the Emergency Medical Services Provider

subsequent incapacity, except as otherwise provided by this section. The durable power of attorney is exercisable as of the date of execution; however, if the durable power of attorney is conditioned upon the principal's lack of capacity to manage property as defined in s. [744.102](#)(10)(a), the durable power of attorney is exercisable upon the delivery of affidavits in paragraphs (4)(c) and (d) to the third party.

**Slide 26**

**Living Will v. DNRO**

- A DNRO is a physician-directed order that addresses a patient's condition
- A living will is a medical expression of future healthcare wishes, either written or oral
- Chapter 765, Florida Statutes, recognizes out-of-state living wills, but not out-of-state DNROs

**Slide 27**

**Do-Not-Resuscitate Order**

A Do-Not-Resuscitate Order (DNRO) is an order written by a physician and signed by the patient or patient's health care surrogate that states, in the event of cardiac or respiratory arrest, no resuscitation efforts shall be attempted. It is part of the prescribed medical treatment.

\* Hand out DNRO Form 1896

**Slides 28 and 29**

**Legal Authority**

- Chapter 401, Florida Statutes
  - Clarifies the patient must be in respiratory or cardiac arrest in order to withhold or withdraw resuscitation
  - Provides immunity from civil or criminal prosecution to EMS personnel for honoring a DNRO
  
- Chapter 765, Florida Statutes
  - Provides authority to a healthcare surrogate, proxy, court-appointed guardian or a durable power of attorney to authorize DNROs
  - Allows the physician to write a DNR order directly in the medical chart.

**Slides 30 and 31**

**Do Not Resuscitate Order Form 1896**

- Signed by the competent patient, or the patient's representative
- Signed by a physician
- On yellow paper, original or copy
- Previous versions are honored
- May be revoked orally or in writing at any time
- Should be displayed in a conspicuous place
- Must be presented to EMS personnel

**Slide 32**

**DNRO Patient Identification Device**

- Portability
- Can be detached, hole-punched, laminated and visibly displayed
- Same validity as DNRO form
- Must be presented to EMS personnel

**Slides 33 and 34**

**Frequently-Asked DNRO Questions**

The following questions are the most frequently asked about the DNRO, and may be a tool for you in providing guidance to people inquiring about the form.

**Who should have a Do-Not-Resuscitate Order?**

Do-Not-Resuscitate Orders are usually reserved for someone who is suffering from a terminal condition, end-stage condition, or is in a persistent vegetative state. There are several types of advance directives that will record the wishes of those not falling into any of the above categories. If you are not sure if you need a DNRO, or you would like additional information on advance directives, it is best to consult your physician as well as an attorney.

**Why should an individual complete a Do-Not-Resuscitate Order if he or she already has a living will?**

A **living will** is a document that instructs, as specifically as possible, what care and treatment the person wishes under certain circumstances. Any competent person can fill out a living will at any time. A **DNRO** is a physician's order **not** to resuscitate if a patient goes into cardiac or respiratory arrest. It is part of the prescribed medical treatment plan and must have a physician's signature. It is usually written for patients who are terminally ill, suffering from an end-stage condition, or who are in a persistent vegetative state.

**In what health care settings is the DNRO form honored?**

Pursuant to Florida law, the DNRO is honored in most healthcare settings, including hospices, adult family-care homes, assisted-living facilities, emergency departments, nursing homes, home health agencies, and in hospitals. Florida law further provides that healthcare providers employed in these healthcare settings may withhold or withdraw cardiopulmonary resuscitation if presented with a DNRO, and be immune from criminal prosecution or civil liability. In addition, if the DNRO is presented to an emergency medical technician or paramedic in a setting other than a healthcare facility it will be honored.

**How will the properly completed DNRO form look?**

The properly completed form will be signed by the competent patient, or the patient's representative, signed by a Florida-licensed physician, and it will be on either the original yellow form or copied onto similar colored paper.

**Will a previous version of the DNRO form be honored?**

Previous versions of the form may also be honored.

**Where should I keep the form?**

The DNRO form should be kept in a noticeable place such as the head or foot of a bed, or on the refrigerator. It should be readily available in the event of an emergency to ensure the patient's last wishes will be honored.

**Can the form be revoked?**

The form can be revoked at any time either orally or in writing, by physical destruction, by failure to present it, or by orally expressing a contrary intent.

**What is a patient-identification device?**

Attached to the bottom of the Department of Health's Form 1896 is a patient-identification device, which may be removed from the form, laminated and worn on a chain around the neck, clipped to a key chain or to clothing/ bed, etc., so it can travel with the patient. It is equally as valid as the DNRO form and can be presented to emergency medical service providers when they arrive on scene. It is designed to allow the patient to move between settings with one document.

**Does the patient identification device need to be completed for the form to be valid?**

No, the patient-identification device is an added option to allow for portability and convenience. It does not have to be completed unless the person wishes to separate it from the form and carry it between settings. Copies of the form on yellow paper will serve the same purpose.

**Should 9-1-1 still be called if the patient has a Do-Not-Resuscitate Order?**

9-1-1 can be called at any time to provide family/caregivers with back up and support for the patient. Many family members call 9-1-1 to control pain and to make sure the patient is comfortable. Others may want the patient to be transported to the hospital so the attending physician will be present. Emergency medical services are part of the community and are able to provide appropriate care as needed in many capacities. A DNRO only means that in the event of cardiac or respiratory arrest, CPR will not be initiated. Comfort care measures, such as oxygen administration, hemorrhage control, and pain management, will still be used.

**Why does the statute state that resuscitation "may" be withheld or withdrawn when presented with a properly completed DNRO instead of "must"?**

Statute was written with the intent that there may be instances when, regardless of the form, the EMT or paramedic may have to rely on his or

## End-of-Life Care for the Emergency Medical Services Provider

her professional discretion. A key example is the person involved in a motor vehicle crash, who could be saved. It was a safety net idea that allowed some interpretation of the event.

### **Where can the Do-Not-Resuscitate Order form be obtained?**

The **Do-Not-Resuscitate Order** Form 1896 can be obtained for free by writing to the Department of Health, Bureau of Emergency Medical Services, 4052 Bald Cypress Way, Bin C18, Tallahassee, FL 32399-1738, by calling (850) 245-4440 ext. 2731 or 2742, or by contacting your local EMS providers. Additional information on advance directives and end-of-life care can be obtained through the Agency for Health Care Administration, Department of Elder Affairs, nursing homes, assisted-living facilities, senior centers, physicians, and local elder-law attorneys. To find out more about what the Bureau of Emergency Medical Services is doing, log on to our web page at [www.doh.state.fl.us](http://www.doh.state.fl.us) and under “view subjects” scroll down to emergency medical services.

**Slides 35 to 43**

**Discussion/Practice Scenarios**

**Scenario Number 1**

A family member faxed a DNRO on white paper for a newly-arrived, nursing home patient. Staff placed it in the chart and the original has not yet arrived. The patient goes into cardiac arrest, what do you do?

**Scenario Number 2**

EMS responds to a school for an 11-year-old boy, for whom there is a DNRO form with an attached parental consent form. The child goes into respiratory arrest while being attended to by EMS in the classroom. How do you handle the situation?

**Scenario Number 3**

You arrive at the scene and find a 32-year-old mother of two young children in cardiac arrest. She has a DNRO identification badge clipped to her robe. No one is at home, but the two young children. The older of the two says he called EMS, paged his father, and he is begging you not to let their mom die. How should you handle this situation?

**Scenario Number 4**

The physician's license number is missing from a DNRO form. The family says the physician refused to put the number on the form for privacy reasons. The patient was reluctant to question the doctor at the time, but is now in cardiac arrest? Can you honor this form? What actions should you take?



## End-of-Life Care for the Emergency Medical Services Provider

### Scenario IV

You arrive on scene to find an 85-year-old female in cardiac arrest. The husband has a living will that states his wife does not wish to have any life-prolonging procedures. The husband is highly agitated and crying. He yells at you not to do anything to his wife because she has suffered from terminal brain cancer for too long. He states that he called EMS because he wanted her transported to the hospital so that she does not die at home.

True    False            1. This living will does not grant you the authority to withhold resuscitative measures.

True    False            2. The husband's response to his wife's death is an appropriate response.

In the scenario above, the lead paramedic turns to the husband and states, "I understand that this must be very difficult for you, and you have every right to be concerned about your wife. You are going through a great deal right now and I'd like to help you through this, but the law is very clear, however, regarding my responsibilities."

True    False            3. This is an appropriate paramedic response to the husband.

## End-of-Life-Care Course Evaluation

1. Were the course objectives adequately identified?  Yes  No
2. Were the course objectives adequately covered?  Yes  No
3. Did the content of this course match its objectives?  Yes  No
4. Was the format of this course sufficient to meet the student's educational needs?  Yes  No
5. Was there adequate time allotted to cover the topic?  Yes  No
6. Were the materials/resources provided useful?  Yes  No
7. Were the teaching methodology/case scenarios supportive in preparing you to apply the course objectives to your work?  Yes  No
8. Were the answers to students' questions applicable to the students' work?  Yes  No

9. If there were any items that you could improve upon, how would you improve the course?

Additional lecture points

More scenarios

More discussion time

Other (please specify) \_\_\_\_\_

10. Did you benefit from this course?  Yes  No

11. Do you feel other EMS personnel would benefit from this course?  Yes  No

Please provide us with any personal or job related end-of-life care scenarios, comments or questions you would like included in the curriculum?

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Please feel free to call 1-800-226-1911, ext. 2731, with any questions, concerns, or input you have about this course or end-of-life care in the pre-hospital environment.