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The problem of withdrawing and withholding medical emergency treatment in the context of paramedic's work from the State Emergency Medical Service

Problem odstąpienia i niepodejmowania medycznych czynności ratunkowych w kontekście pracy ratowników medycznych systemu Państwowe Ratownictwo Medyczne

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Summary

The issues of withdrawing and withholding medical emergency treatment are regulated by the Act of 8 September 2006 on the State Emergency Medical Services (Journal of laws of 2016, item 1868). But unfortunately, the legislator did not indicate the factors which can make it easier for the paramedics to decide on abandonment or discontinuation of medical rescue treatment.

As there are numerous doubts and ambiguities within the analysed context, the best and the most reasonable solution for the paramedics in the basic emergency medical teams to apply the same principles that are used by the specialised emergency medical teams with regard to Article 41 of the Act on the State Emergency Medical Services. In this Article, the legislator underlined that the medical rescue action of a basic emergency team should always be coordinated by the paramedic appointed by the medical dispatcher. At the same time, the legislator indicates that while conducting medical rescue treatment, the person supervising the action should be in constant contact with the medical dispatcher to consult the doctor selected by the dispatcher.

This paper aims to familiarise the reader with the issue of withdrawing and withholding medical emergency care and problems related with these issues. The authors will also present the concept of a card of withdrawing medical emergency treatment. Such a card would be especially helpful to paramedics in the situations when they have to make these hard decisions. So far, the attempts of implementing such a card in common practice of medical emergency teams have not been successful, leaving the personnel to make decisions on their own.

Streszczenie

Zagadnienia odstąpienia od medycznych czynności ratunkowych oraz niepodejmowania medycznych czynności ratunkowych regulowane są zapisami ustawy z dnia 8 września 2006 r. o Państwowym Ratownictwie Medycznym (Dz. U. 2016 poz. 1868). Niestety ustawodawca nie wskazał czynników, które mogą ułatwić ratownikom medycznym decyzję o zaniechaniu medycznych czynności ratunkowych lub odstąpieniu od medycznych czynności ratunkowych.

W związku z mnogością wątpliwości oraz niejasności występujących w kontekście analizowanego problemu najlepszym oraz najbardziej rozsądnym rozwiązaniem jest stosowanie się ratowników medycznych pracujących w podstawowych zespołach ratownictwa medycznego do tych samych wytycznych, jakimi kierują się specjalistyczne zespoły ratownictwa medycznego z równoczesnym uwzględnieniem art. 41 ustawy o Państwowym Ratownictwie Medycznym. W artykule tym ustawodawca zaznaczył, że akcją prowadzenia medycznych czynności ratunkowych przez podstawowy zespół ratownictwa medycznego zawsze kieruje ratownik medyczny wyznaczony przez dyspozytora medycznego. Równocześnie ustawodawca wskazuje, że podczas prowadzenia medycznych czynności ratunkowych kierujący akcją pozostaje w stałym kontakcie z dyspozytorem medycznym, dzięki czemu w każdej chwili może on zasięgnąć opinii lekarza wskazanego przez dyspozytora medycznego.

Niniejszy artykuł stanowi próbę przybliżenia zagadnień zaniechania medycznych czynności ratunkowych i odstąpienia od medycznych czynności ratunkowych oraz wskazania problematyki związanej z tymi zagadnieniami. Przedstawione w nim zostanie także zagadnienie karty odstąpienia od medycznych czynności ratunkowych, która mogłaby okazać się niezwykle pomocna ratownikom medycznym w podejmowaniu tych jakże trudnych decyzji. Dotychczas nie udało się wdrożyć projektu takiej karty do powszechnego użytku, a ratownicy medyczni muszą samodzielnie podejmować decyzje w tym zakresie.

INTRODUCTION

One of the most difficult decisions in the work of a medical emergency team (MET) is to withhold medical emergency care. The issues of withdrawing and withholding medical emergency treatment are regulated by the Act of 8 September 2006 on the State Emergency Medical Services (Journal of laws of 2016, item 1868). This act indicates that the basic medical emergency teams in the course of performing their statutory duties and undertaking medical emergency treatment may be involved in incidents when there is a need to discontinue the above mentioned treatment and subsequently declare death (1).

MEDICAL EMERGENCY TREATMENT

The medical emergency treatment (MET) consist of healthcare services within the meaning of the provisions on health care services financed from public funds which are provided by the State Emergency Medical Services unit in an out-of-hospital setting and which are undertaken to rescue a person when his/her health is endangered (2).

The legislator also specified two categories of medical emergency treatment which may be performed by emergency medical technicians independently or under the physician's supervision. The actions that may be undertaken by a paramedic independently include, among others, assessment of the patient's condition in order to decide on treatment and the decision on starting or withdrawing medical emergency treatment. At this point, the legislator failed to specify the principles on the basis of which the paramedic may withdraw medical emergency treatment (3), therefore the majority of emergency medical technicians encounter real problems with interpreting this law, and consequently with proper performance of their duties.

In the cited case, in the opinion of both the practising paramedics and medical law specialists the most reasonable approach to start or refrain from medical emergency treatment is to follow the current guidelines on carrying out cardiopulmonary resuscitation. Specialists underline that in many situations of out-of-hospital cardiac arrest the paramedics face the dilemma whether to take up or withdraw medical emergency treatment, while the time spent on solving these issues often extends the entire procedure of providing prehospital care (3).

As a rule, in out-of-hospital cardiac arrest a resuscitation should be instituted and continued until the signs of life return. It is also assumed that the cardiopulmonary resuscitation should not be undertaken when the victim has extensive wounds that give little chance of survival. The above mentioned fatal injuries on the basis of which medical emergency treatment should be withheld include, among others, decapitation, severed trunk, prolonged submersion in water, charring of the body, rigor mortis, and foetal maceration. In these cases the medical emergency technicians may declare death (4).

Yet it is even more difficult for a paramedic to decide when to stop performing cardiopulmonary resuscitation and this decision is one of the signs of withdrawal from medical emergency treatment. In such cases, often many questions arise whether the rescuers should declare death of the victim after 20 minutes of asystole when there are no reversible causes or when there are no effects of CPR visible on site and while transporting the victim to the nearest Hospital Emergency Department (ED) or Trauma Centre (TC). The analysis of available literature shows that there are many conflicting views as to how paramedics should act in such situations. These conflicts stem from national legal provisions relating to prehospital care and the possibility of withdrawing from making the cardiopulmonary resuscitation. In some countries, the CPR is a routine procedure, so the paramedics are not expected to continue resuscitation when the physician has resigned, in this case it is unjustified. Therefore, in these countries the paramedic may with-

draw from performing cardiopulmonary resuscitation in the same circumstances as would the physician. Yet every time the CPR is discontinued, where is no circulation, it is necessary to write down the exact time when the resuscitation was stopped and the paramedic should justify his/her decision (3).

The Polish Resuscitation Council indicates that, in the described circumstances the specialised medical emergency teams should follow the rule to continue the cardiopulmonary resuscitation so long as the ventricular fibrillation persists. At the same time, it is generally accepted to abandon the procedure after 20 minutes of asystole when there is no reversible cause of cardiac arrest and when all the advanced resuscitation operations are employed (4).

As there are numerous doubts and ambiguities within the analysed context, the best and most reasonable solution to this problem is to apply by the paramedics of the basic emergency medical teams the same principles that are used by the specialised emergency medical teams and to have regard to Article 41 of the Act on the State Emergency Medical Services. In this Article, the legislator underlined that the medical rescue action undertaken the basic emergency team should always be coordinated by the paramedic appointed by medical dispatcher. At the same time, the legislator indicates that while conducting medical emergency treatment, the person coordinating the action should be in constant contact with the medical dispatcher to have the possibility to consult the doctor selected by the dispatcher (1).

It would be useful to have a Card of Withdrawal from the Medical Emergency Treatment, a draft of which has been promoted by the professionals connected to prehospital emergency treatment (5).

WITHHOLDING THE MEDICAL EMERGENCY TREATMENT

In the draft of the Card of Withdrawal from the Medical Emergency Treatment two essential and very problematic issues are named and addressed. The first issue is refraining from the medical emergency treatment which is called withholding the medical emergency treatment. In legal terms, withholding is defined as a conduct of a person resulting in legal consequences even when the person did not intend to cause such consequences. Withholding may be committed by purposeful inaction, that is refraining from action. Withholding may be legal or illegal (6).

In the said card, the factors that make it possible for a paramedic to withhold from the medical emergency treatment are specified as below:

- the presence of certain signs of death in the victim,
- the presence of injuries on the victim's body which make the resuscitation fruitless,
- occurrence of a direct life-threatening situation for a paramedic if he/she attempts to start medical emergency treatment.

If the paramedic states the absence of vital signs and having conducted examination or inspection of the body, he/she can indicate certain signs of death. These signs include, above all, livor mortis, rigor mortis, algor mortis, pallor mortis, exsiccation, autolysis and putrefaction. If the medical emergency technician states one of them, then undertaking any medical emergency activities will be not only ineffective, but also ungrounded. One of the situations when the paramedic may refrain from rescue operations is cardiac arrest in patient during the course of a terminal stage of cancer (5).

As mentioned above, body injuries that are not likely to result in successful resuscitation are also the reason to abandon the rescue operations. These injuries may include, above all, severe crush injuries, disintegrating or dismemberment of the body or other extensive wounds, multiple open wounds, brain injuries, decapitation, foetal maceration, and charred body. All these should be described in detail as well as their site and size on the victim's body.

The last indication to refrain from medical emergency treatment is direct life-threat for the paramedic if he/she attempts to start rescue operations. In this case, it is necessary to describe the situation which is life-threatening for the paramedic as well as to describe other actions undertaken to minimise the consequences of such incidence.

WITHDRAWAL FROM MEDICAL EMERGENCY TREATMENT

The second possibility provided by the legislator to the paramedics is the withdrawal from medical emergency treatment. In the suggested Card of Withdrawal from Medical Emergency Treatment, two situations are described that enable the paramedics to abandon the rescue operations, mainly:

- asystole which persists for over 20 minutes – in this case the paramedic must produce the protocol confirming the asystole,
- and direct life-threatening situation for the paramedic if he/she continues to perform the rescue operations.

It is recommended that when the mechanism of sudden cardiac arrest (SCA) is the asystole, then the medical team may withdraw medical emergency treatment. It has to persists for minimum 20 minutes and be confirmed with protocol of asystole. However, at this point it should be emphasised that in order to withdraw from providing medical assistance in asystole, three criteria should be met:

- all available methods, instrumental or non-instrumental, have been utilised in cardiopulmonary resuscitation,
- reversible causes of sudden cardiac arrest (SCA) in the victim have been ruled out,
- the victim has wide, non-responsive pupils (but it should be borne in mind that while assisting the patient when his/her life is threatened, the

evaluation of pupils is not the criterium to abandon medical emergency treatment).

It is also underlined that in each case when the rhythm is not caused by asystole, the CPR should be continued unless this rhythm changes into asystole. The contraindications to withdraw medical emergency treatment are, as previously indicated, reversible causes of cardiac arrest, especially if they accompany the following conditions:

- pregnancy,
- hypoglycaemia,
- hypoxia,
- hypothermia,
- hypovolaemia,
- tension pneumothorax,
- electrocution,
- electrocution by lightning,
- cardiac tamponade,
- electrolyte disturbances,
- pulmonary embolism,
- coronary embolism,
- intoxications.

Continuing medical emergency treatment is also contraindicated when the life of medical emergency technician is threatened, for example in fire, collapsing building, burning car etc.

CONCLUSIONS

Withdrawing and withholding medical emergency treatment each time is a very difficult and hugely problematic issue for the paramedic. The problem is caused mainly by lack of clear instructions in the legislation as to when to refrain from or abandon the medical emergency procedures. Here, it would be very helpful to have a Card of Withdrawal from Medical Emergency Treatment. Implementing such a tool which would be a standard or a rule of procedure in the circumstances described above needs consultations in the circles of paramedics, physicians, nurses, and lawyers dealing with medical law.

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