To The Editor:

In recent issues of this journal, R. Jack Ayres and I have exchanged views on the medical/legal aspects of the prehospital resuscitation decision-making process. This interchange began with Mr. Ayres' thoughtful CME article, *Current Controversies in Prehospital Resuscitation of the Terminally Ill Patient* published in the January–March 1990 issue (Vol. 5, No. 1). It continued with my letter to the editor published in the October 1990 issue (Vol. 5, No.). I now write in response to Mr. Ayres' reply to my letter (*Prehospital and Disaster Medicine* Vol. 6, No. 1).

n his reply, Mr. Ayres vehemently takes issue with my comments on the complexities of prehospital resuscitation decision-making and the conclusions drawn by the author in his original article. I do not intend here to further argue the technical issues surrounding this complicated convergence of law and medicine. However, I feel compelled to offer a few additional and closing comments.

Mr. Ayres original article suggests and describes in detail, the complex fabric of medical, legal and ethical threads running through the issues presented. The feeling which strikes the reader is that the medical/legal bureaucracy which imposes protocols, procedures, definitions, medical judgment and legal analysis buries the patient.

This invisible patient no longer has a functioning will or cogent desires. The role of the patient according to some, is subservient and secondary to the needs of the medical/legal community to meet the elusive "standard of care" and to vanquish any guilt at being unable to "save" a dying patient in a strict adherence to artificial medical ethical standards.

Mr. Ayres relies almost entirely on guidelines developed by ACEP, NAEMSP and AHA to support his arguments. There is no *legal* presumption that these guidelines, if followed, will provide the legally correct course of conduct in any given jurisdiction.

Another over-simplification concerns the discussion of discriminatory resuscitation practices. The arbitrary selection of patients solely on the basis of age, economic status, or circumstance of living is *"fraught with peril."*[1]

As best I can tell from Mr. Ayres' reply, our differences relate to two main points. First, the manner in which refusals in the field setting are conveyed by the patient, the patient's surrogate or the patient's physician. Second, the manner in which field personnel and medical directors may recognize and act upon those refusals. At the heart of our interchange is the notion that prehospital resuscitation decision-making involves a balancing of rights and interests. On the one hand is the patient's right of self-determination; on the other is the health care provider's oft stated interest in preserving life.

Mr. Ayres writes, "Unless the directive to a physician, durable power of attorney, or *other legal instrument. . .*has been reviewed previously and found to be medically and legally appropriate by the medical director and designated legal advisor for the EMS system, *such documents cannot be relied upon in an emergency.*"(emphasis added).[2] He goes further, "Under no circumstances should a physician medical director or EMS provider undertake to determine the nature, extent, or finality of a court order without legal advice."[3]

Is Mr. Ayres advising the medical provider to virtually ignore a court order? Notably absent from his article is any discussion of the process involved to obtain such an order which includes a hearing on the issues before a judge with the patient, patient's representative, and medical provider given the right to be heard. Ignoring a court order is fraught with peril. It is contempt of court in most states.

Ignoring a valid living will, durable power of attorney, or court order pits the medical community against the wishes and right of self-determination of the patient. This right is guaranteed under the federal constitution and cannot be undermined by medicine.[4] This right to be left alone frequently conflicts with medicine's desire to intervene. However, the medical provider has no constitutionally protected interest in providing care.

In his response, Mr. Ayres argues that "prudence" should dictate the provider's course of conduct. Prudence as defined by Mr. Ayres is to maintain life, at any cost, ignoring the patient's constitutionally guaranteed and morally defensible right of self-determination.

I acknowledge that often it is physically and legally impossible to obtain consent from dying patients prior to imposing DNR orders. That does not absolve the medical/legal community from drafting and incorporating policies and procedures which recognize that the medical/legal community *serves* the needs of the patient and not the reverse.

The medical community must become educated and sensitized to the self-determination rights of patients in the resuscitation decision making process. Mr. Ayres' article contributes to this process of education. Public debate, by definition, includes spirited public exchange of ideas and beliefs. Only through public debate can education prosper. My original comments, as with any public debate, should not be expected to duplicate that of any other commentator. Mr. Ayres and I simply represent different voices in the same debate.

Because there are no right answers in this volatile area, the NAEMSP currently is confronting the issue by developing a consensus document addressing the prehospital resuscitation decision-making process. Mr. Ayres and I are each working with the Ethics Committee toward that end. With the clashing differences of opinion he and I hold on some of these issues, it is my hope that the consensus document created will represent a balanced, sensitive and adaptable policy which recognizes and respects the needs of all participants.

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Endnotes

1. Ayres article, p. 52.
2. Ayres article, p. 54. provider undertake to determine the nature, extent, or finality of a court order without legal advice."
3. Ayres article, p. 55
4. A competent person has a *constitutionally protected liberty interest* in refusing unwanted medical treatment under the Fourteenth Amendment of the U.S. Constitution. *Cruzan v. Missouri Department of Health*, 497 U.S. 110 S. Ct. 2841 (1990).