DNR Issues In Airport And Airline AED Programmes: The Need For Dialogue And Openness In Developing Policy

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Abstract

This paper is concerned with the safeguarding of patient autonomy in the context of early defibrillation (AED) programmes, with particular reference to airlines and airports. It focusses especially on the role of out-of-hospital Do-Not-Resuscitate (OOH-DNR) orders as a means of communication with non-physician first responders. The ethical and legal issues surrounding OOH-DNR orders and lay first responders are briefly discussed. The implications of extending 'Good Samaritan' protection to operators unschooled in the determination of advance directives are raised. Most of all, the paper stresses the importance of wide consultation and open publicity regarding the DNR policy of any AED programme.

In recent years, the use of automated external defibrillators (AEDs) by laypersons - both trained and, in some cases, untrained - has become increasingly widespread. Among the most enthusiastic adopters of AEDs have been commercial passenger airlines and airports. The Australian carrier QANTAS was the first to equip its fleet with AEDs [1] and since then a large number of both major and minor airlines have followed suit. As a result of federal legislation, all US-based carriers are now obliged to carry AEDs and train flight attendants in their use [2, 3]. Amongst other AED-equipped carriers are the Brazilian airline Varig [4], German Lufthansa [5], Air France [6], South African Airlines [7], British Airways [8], and Virgin Atlantic [9]. With regard to airport programmes, the one at Chicago's O'Hare Airport is probably the most widely publicized [10], though many airports, including London's Heathrow and a number of smaller UK airports, now have similar provision [11].

INTRODUCTION

A considerable number of papers have been published which focus on the clinical effectiveness of early defibrillation. However, when discussing the contribution of AEDs, it is important also not to lose sight of those who, on whatever grounds, have exercised their ethical and legal right to refuse this intervention.

It is for this reason that, over the past few years, states such as West Virginia have enacted laws enabling out-of-hospital Do-Not-Resuscitate (OOH-DNR) orders, which document advance refusals of resuscitation for the benefit of emergency responders [12]. In West Virginia, the AED law also explicitly requires that AED users receive training in "the determination of advance directives" [13]. 'Good Samaritan' immunity is only offered by the West Virginia AED law to those in compliance with the requirements of §3, which include this training requirement [14]. In certain places, it is also apparent that all first responders, and not just ambulance paramedics, are expected to honour these OOH-DNR orders - cf. the definition of 'EMS Personnel' in the New Jersey guidelines, which includes police officers and the general statement "others trained in CPR" [15].

DISCUSSION

In the conclusion to their review of the AED programme at Chicago's O'Hare airport, Caffrey, Willoughby, Pepe and Becker have suggested that "lack of ... training should not constrain attempts to use a defibrillator in emergencies" and that "reasonable public health strategies would be to promulgate good-Samaritan laws" [10]. However, several other authors have already stressed the importance of patient autonomy in the context of AED programmes [16, 17, 18, 19]

and it seems important that the doctrine of Good Samaritan protection should not develop to the extent where it implies carte blanche to treat people against their expressed wishes. With untrained operators, there is a considerable danger of this happening, and the training requirements laid down by AED laws, such as the West Virginia law, are designed to help avoid this problem. The risk from untrained operators is unlikely to be an issue in the context of airlines, where only the flight attendants have access to the AED and should be properly trained in its use, but it does pose a risk where open public-access defibrillation is being considered, for instance, in airport terminals.

In the context of OOH-DNR orders, the Association of Emergency Physicians has stated that "AEP does not support resuscitation of any patient against their wishes" [20]. However, in making this statement, the AEP also stressed the need for wide-ranging dialogue in developing effective OOH-DNR policies: "AEP believes that it is unethical and impractical to expect EMS units to address a decision as important as a DNR status during a medical emergency. This type of personal medical decision is best addressed by a competent patient and their personal physician prior to a potentially terminal medical event. The involvement of legal guardians, families, lawyers, legislators, EMS agencies and medical personnel is necessary to place in effect a comprehensive program to address this issue in each community" [20]. Laws such as the West Virginia Do-Not-Resuscitate Act and consensual protocols such as those adopted in New Jersey are a logical result of this kind of dialogue. However, such legislation and protocols can still sometimes leave key questions unresolved - for example, inter-state and inter-country reciprocity or whether an institution may have a blanket policy of refusing to honour OOH-DNR orders. In the latter case, there is already evidence of conflicting legal views: for example, having taken legal advice, the Los Lunas Schools Board in New Mexico has a stated policy of not honouring students' DNR orders [21], whilst, in contrast, the Maryland Attorney General has advised that public schools in Maryland must honour such orders [22].

The twin issues of reciprocity and the right not to honour an OOH-DNR order are also important legal issues for airlines and airports. They are of particular relevance here, since airlines and airports act as host to people from many different places and the airlines fly through the airspace of many states and countries. As a consequence of this potentially complex legal situation, some airlines, such as ATA, have openly resolved to adopt a policy of not honouring DNR orders, such that agreeing to travel with them constitutes an informed consent to treatment if the circumstances arise [23].

CONCLUSION

Regardless of whether or not one agrees with the substance of this policy, ATA's publication of its position can be viewed as an example of good practice, since a facility's or an airline's policy on DNR issues should always be a matter of readily accessible public record. In the case of an airline, this information should be freely available to the potential passenger before booking a ticket, as it is with ATA. If it is not, then their decision to travel would not constitute an informed consent to resuscitation, if the clinical need arose. They should not have to ask specially to see the policy.

Aside from the perspective of legal liability, however, the act of not honouring a DNR order which results from informed refusal of consent still remains an ethical dilemma. If all airlines and airports were to adopt a "no DNR" policy, people would have their freedom to travel severely curtailed or else be forced, if the situation arose, to accept treatment to which they do not freely consent. Rather than leave things as they stand, therefore, steps should be taken on a broader scale to clarify the situation and, if necessary, to develop further appropriate legislation and/or protocols towards a solution which is both ethical and legal. In doing this, those setting up or managing AED programmes should engage actively in open dialogue with ethicists, lawyers, attorneys general and the general public with regard to required training levels, ethical safeguards, and the treatment of advance directives and DNR orders. Whatever the decisions finally taken, they should be taken on the basis of wide consultation involving all shades of opinion and should always be a matter of readily accessible public record.

References

1. O'Rourke MF, Donaldson E, Geddes JS. An airline cardiac arrest program. Circulation. 1997 Nov 4;96(9):2849-53.
2. Emergency Medical Equipment, 14 C.F.R. Sect. 121. Appx. A (2000, as amended).
3. Crewmember training for in-flight medical events, 14 C.F.R. Sect. 121.805 (2000).
4. Alves PM, de Freitas EJ, Mathias HA, da Motta AE, Silva Rde C, Muller M, Almeida SF, Stapleton E, Timerman S, Ramires JA. Use of automated external defibrillators in a Brazilian airline. A 1-year experience. Arq Bras Cardiol. 2001 Apr;76(4):310-4.
5. Von Mülmann MJA. Flugreisetauglichkeit. Notfall &

Rettungsmedizin 2002 Oct;5(6):411-24.
6. Lapostolle F, Mahaut JM, Crocheton N, Levasseur J, Adnet F. Utilisation d'un défibrillateur semi-automatique (DSA) au cours du transport aérien. Ann Fr Anesth Reanim. 2003 Mar;22(3):235-7.
7. South African Civil Aviation Authority Medical Department. SAA introduces AEDs [editorial]. Medex Bulletin [serial online] 2001 May [cited 2004 Mar 8]; [1 screen]. Available from: URL: http://www.caa.co.za/publications_files/Medex/2001%5CMEDEX%20BULLETIN%20-May%202001.htm
8. British Airways. Medical care in the air [cited 2004 Mar 8]; [3 screens]. Available from: URL: http://www.britishairways.com/travel/healthcare/public/en_.
9. Virgin Atlantic. Press information kit [cited 2004 Mar 8]. Available from: URL: http://www.virgin-atlantic.com/pdf/vaa-press-kit.pdf.
10. Caffrey SL, Willoughby PJ, Pepe PE, Becker LB. Public use of automated external defibrillators. N Engl J Med. 2002;347:1242-1247.
11. Davies CS, Colquhoun M, Graham S, Evans T, Chamberlain D; Defibrillator Advisory Committee. Defibrillators in public places: the introduction of a national scheme for public access defibrillation in England. Resuscitation. 2002 Jan;52(1):13-21.
12. West Virginia Code §16-30C.
13. West Virginia Code §16-4D-3 (2).
14. West Virginia Code §16-4D-4 (1).
15. Medical Society of New Jersey. New Jersey Do-Not-Resuscitate (DNR) Orders outside of the hospital: guidelines for healthcare professionals, patients and their families. August 2003 [cited 2004 Mar 8]. Available from: URL: http://www.njha.com/ps/pdf/dnr.pdf.
16. Borrillo DJ. DNR, aisle, or window? The Federal Air Surgeon's Medical Bulletin [serial online] 1998 Winter [cited 2004 Mar 8];[2 screens]. Available from: URL: http://www.cami.jccbi.gov/AAM-400A/FASMB/FAS9804/dnr.htm.
17. Beaumont E. Teaching colleagues and the general public about automatic external defibrillators. Prog Cardiovasc Nurs. 2001 Winter;16(1):26-9.
18. Riegel B. Training nontraditional responders to use automated external defibrillators. Am J Crit Care. 1998 Nov;7(6):402-10.
19. Scheetz A. Informed consent for public automated external defibrillation. JAMA. 2001 Jul 4;286(1):47.
20. Association of Emergency Physicians. Pre-Hospital Do Not Resuscitate Orders [cited 2004 Mar 8]. Available from: URL: http://www.aep.org/policy.asp#Pre-Hospital Do Not Resuscitate Orders.
21. Los Lunas Schools Board. Non-compliance with "do not resuscitate" orders for students. Los Lunas Schools Board Policy 7-25 [cited 2004 Mar 8];[2 screens]. Available from: URL: http://www.loslunas.k12.nm.us/district/masterbp/Sec7/7-25.htm.
22. Maryland Attorney General. School officials may not perform emergency procedures on terminally ill child that are contrary to parents' decision and physician's order. 79 Opinions of the Attorney General 244 (1994) [cited 2004 Mar 8]. Available from: URL: http://www.oag.state.md.us/Opinions/1994/79oag244.pdf.
23. ATA Airlines Inc. Customer Service Plan Initiative 7 [cited 2004 Mar 8]. Available from: URL: http://www.ata.com/pdfs_docs/csplan/Initiative7.pdf.

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