Non-standard Advance Directives in Emergency Medicine:

What Should We Do?

A recent publication that received widespread media attention described an interesting, but hardly unique, occurrence of an unconscious emergency department (ED) patient with a non-standard advance directive—in this case, a “Do Not Resuscitate” tattoo across his chest.1 The authors’ advice and subsequent media reports suggest that what ED and prehospital clinicians should do in these situations is unclear; it isn’t. Since this type of critical scenario occurs with some regularity, clarification of emergency physicians’ clinical options and the ethical ramifications may be useful.

When ED or prehospital patients who lack decision-making capacity present in critical condition, and an ethical course of action is unclear, there are often ways to buy time to obtain additional information or to consult with those more familiar with ethical issues.2 If the patients present with a non-standard advance directive, clinicians must immediately address the question of whether to withhold treatment based on what may or may not be a valid patient directive. Without such additional information, the moral weight will always favor initiating treatment, since withholding treatment is often irreversible and any treatment instituted can later be withdrawn.3

Non-standard advance directives, most commonly indicating “Do Not Resuscitate,” offer only general direction to clinicians. This non-specific language is also found in most living wills. For that reason, living wills have been largely replaced with more flexible or
specific Durable Powers of Attorney for Healthcare (DPAHs), which name one or more specific surrogate decision-makers, Physician Order for Life-Sustaining Treatment (POLST) orders, and similar advance directives.

When faced with non-standard directives, physicians can follow them, ignore them, or simply use them as an additional piece of information about the individual’s wishes for some situations at one point in his or her life. Confusingly, in the recently published case, the medical team seemed to first ignore the directive and then, when the clinical situation appeared nearly hopeless, to use it as a partial justification to cease additional aggressive treatment.

I encountered my first non-standard advance directive when a renowned emergency medicine (EM) educator and colleague, who was in generally good health, had an international "do not defibrillate" symbol tattooed over his point of maximum impulse on his 65th birthday. While such an action can be a response to retirement, illness, or depression, he explained his rationale as a principled statement about the futility in continuing ACLS on patients in the ED who do not respond to prehospital resuscitative efforts. Discouraged by their poor neurological outcomes, he remarked that “I don't mind dying, but I sure as hell do not want to spend days, months, or years in a nursing home bouncing beach balls in a parachute blanket.” After extended discussions on the ambiguities inherent in an advance directive tattoo, he agreed that no EM colleague should consider it anything more than his disgust at the then (1992) state of cardiac resuscitation.
Discussing the validity of that non-standard directive proved extremely useful when, several years later, an unconscious and critically injured patient presented to the ED in need of an immediate life-saving laparotomy. Just as the staff was unlocking the stretcher wheels to move her to the OR for an emergent laparotomy, the nurse removed her last piece of jewelry, a simple metal disc hanging from a chain around her neck. As the nurse extended the medallion for me to see, she said, simply, “DNR.” Everything and everyone stopped immediately, and the room fell silent. Because of the previous, analogous discussions regarding what this directive did—or, more to the point, did not—indicate, I was immediately able to instruct the team to proceed to the OR. The patient later wrote to say that she was grateful that I had not misinterpreted her medallion, which, she said, was only meant to keep her from a prolonged death in the ICU.

The take-home message is that advance directives have been standardized for a good reason. ED or prehospital healthcare providers must be able to immediately interpret and act on them without needing a legal interpretation. Absent the patient’s input or that of a knowledgeable surrogate, both the patient’s initial reasons for their non-standard directive and his or her present wishes concerning resuscitation cannot be independently known. Therefore, healthcare providers must initiate treatment while they buy time, attempt to return the patient to lucidity, and search for probative information regarding their current wishes concerning medical treatment.


