**Ethical Issues of Resuscitation**

 **Approved by the ACEP Board of Directors June 2008 titled, "Ethical Issues of Resuscitation" by combining, "Ethical Issues of Resuscitation" approved October 2001 and "Do Not Attempt Resuscitation (DNAR in the Out-of-Hospital Setting" approved September 2003**

The American College of Emergency Physicians supports the following principles.

* Patients who may benefit from resuscitation efforts should have equitable access to such efforts.
* Decisions to attempt resuscitation must take into account, the accepted standards of medical care as well as patient preferences, if known,

 All emergency medical services (EMS) systems should have a policy addressing their response to ‘Do Not Attempt Resuscitation’ (DNAR) orders and other advance directives. Public and patient education information regarding such policies should be disseminated to the community, and among out-of-hospital and hospital providers. Out-of-hospital orders and directives used by EMS personnel (for examples, ‘Do Not Resuscitate’ (DNR), Do Not Attempt Resuscitation (DNAR), EMS-DNR, POLST, MOLST, etc.) may be used to document decisions to limit or forgo resuscitation efforts at the end of life. Such orders indicating patient preferences should be honored by out-of-hospital providers.

 If the patients’ preferences regarding resuscitation are clear, they should be respected. Patient preferences to refuse resuscitative efforts can be communicated directly by the patient, or by an advance directive, a valid Do Not Attempt Resuscitation (DNAR) order, or by the patient’s legal representative. Unofficial documentation may be considered when determining patient preferences.

If the wishes of the patient are unclear, medically appropriate resuscitative measures should be undertaken. It is ethically permissible for treatments, once started, to be withdrawn when additional information is available. This information may include the lack of response to treatment or definitive information about the patient’s wishes.

Surrogates, such as those authorized by statues or a patient’s valid durable power of attorney for health care, should be involved in decisions whether to attempt resuscitation, if available in a timely fashion.

The patient’s primary physician and family should, when feasible, be contacted in order to clarify the wishes of the patient regarding ongoing resuscitative efforts. They should not overrule a valid advance directive.

Emergency physicians should familiarize themselves with applicable state and federal laws regarding advance directives and health care proxies.

It is appropriate for out-of-hospital providers to honor valid DNAR orders or out-of-hospital advance directives. Standardized guidelines and protocols should be developed to direct out-of-hospital personnel’s resuscitative efforts.

When resuscitative efforts are not indicated, emergency physicians should provide appropriate medical and psychosocial care during the dying process. This may include the provision of comfort measures and psychosocial support for the patient and family.

 Resuscitative efforts may be appropriately withheld, withdrawn or limited, in some circumstances, such as patient preferences, an immediate limitation of resuscitation resources, or when it is physiologically impossible or judged that there is no realistic likelihood of benefit to the patient, based on scientific evidence.

<http://www.acep.org/Clinical---Practice-Management/Ethical-Issues-of-Resuscitation/> green