Medical Xpress

Stop taking patients in cardiac arrest to hospital, says expert

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It's time to stop taking patients in cardiac arrest to hospital and let ambulance crews deliver the best possible care at the scene, argues a senior UK doctor in *The BMJ* this week. But a senior US doctor warns that avoiding ambulance transport could result in unacceptable deaths.

Cardiac arrest outside of hospital is a common and catastrophic medical emergency experienced by about 60,000 people a year in the UK. Less than 10% survive to discharge from hospital.

Immediate cardiopulmonary resuscitation (CPR) offers the best chance of survival and ambulance services throughout the developed world tend to take patients in cardiac arrest to hospital, with CPR ongoing.

This seems intuitive, writes Jonathan Benger, Professor of Emergency Care at the University of the West of England, and Consultant at University Hospitals Bristol NHS Foundation Trust, but he says "hospitals have nothing to offer almost all such patients beyond the care that is provided by a well trained and equipped ambulance service."

Furthermore, taking such patients to hospital may be actively harmful, he warns.

He believes this has to stop. "Ambulance staff must be empowered to use their skills to optimise CPR, achieve early defibrillation, and deliver the best possible care at the scene, with no thought of transport until spontaneous circulation has returned or until it becomes clear that the

patient has no chance of survival," he writes.

Once spontaneous circulation has returned, the patient should be stabilised and transported to a "heart attack" centre for ongoing care. And if spontaneous circulation does not return then the patient's death "should be accepted and made as dignified as possible."

He acknowledges that, in rare circumstances, transport to hospital is justified, but says this should be delivered by a specialist team.

"For the vast majority of patients, however, it is time to call a halt to transport in cardiac arrest and to concentrate on providing the best possible resuscitation skills at scene, empowering and supporting ambulance staff. More must also be done to educate staff and the public about best possible care and what to expect when cardiac arrest occurs outside hospital," he concludes.

But Bruce Adams, Chair of emergency medicine at the University of Texas Health Sciences Center, says rules for deciding when to stop resuscitation are fallible and can result in unacceptable deaths.

He points out that the quality of CPR and survival outcomes "vary strikingly with geography, further complicating the application of guidelines on when to stop resuscitation."

And he argues that the costs of CPR survival are overstated. "Avoiding ambulance transport of every patient with a cardiac arrest who died in the emergency room would save the US Medicare programme only $58m, which is less than 0.1% of its total annual losses from fraud alone," he explains.

The rate of ambulance crashes with full lights and sirens is 46 per 100,000 patient journeys, he says. "We would need to halt 2,178

ambulance transports to prevent a single injury, but that effort would result in more than 20 unnecessary deaths."

Furthermore, the fear that CPR creates long term neurovegetative survivors is not borne out by the data, he adds. "For the most part, patients that are destined to die do so fairly soon."

Meanwhile, an estimated 5% of all organs harvested are from legally brain dead patients who received CPR, "so reducing ambulance transport of patients in cardiac arrest could diminish organ donations."

Finally, he points to emerging advances in CPR research, saying "these promising hospital based resuscitative strategies may change our definition of who is and who is not salvageable."

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