

The new ABCs: Airway, Breathing, and Court injunctions

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RÉSUMÉ : Jusqu'à quel point la loi s'est-elle immiscée dans la pratique médicale? Les tribunaux peuvent-ils nous «obliger» à réanimer des patients lorsque nous jugeons l'intervention inutile? M. A.S., un homme âgé de 79 ans arrive difficilement à parler et à avaler à la suite de plusieurs AVC. Il a subi une trachéostomie et il ne peut exprimer ses propres souhaits. En 1998, lorsqu'il fut admis dans un hôpital de réadaptation, ses médecins rédigèrent un ordre de ne pas réanimer. Par la suite, comme l'ont rapporté les journaux, l'épouse de M. A.S. obtint une injonction «obligeant» le personnel de l'hôpital à administrer la réanimation dans le cas d'un arrêt cardiaque. Cette cause bien connue est présentement en litige devant les tribunaux du Manitoba. Qui a le dernier mot lorsque les médecins et les patients sont en désaccord? Quelles leçons doivent en tirer les médecins d'urgence? Le présent article discute des questions éthiques entourant la réanimation.

Introduction

How far has the law intruded into medical practice? Can courts “force” us to resuscitate patients when we don't believe they will benefit from the procedure? These difficult questions are being raised in a Manitoba courtroom, and the case, described here, has been widely reported in the press. Emergency physicians should pay attention.

Mr. A.S. is a 79-year-old man whose ability to speak and swallow has been impaired by a number of serious strokes. He has a tracheostomy and cannot clearly express his own wishes. In the spring of 1998 when he was admitted to a rehabilitation hospital, his physicians felt he would not benefit from cardiopulmonary resuscitation and wrote a do-not-resuscitate (DNR) order. Subsequently Mr. A.S.'s wife demanded that the order be removed, and the hospital took the unusual step of having her declared unfit to act as his surrogate decision-maker. Mrs. S. then obtained a temporary injunction that “forces” hospital staff to provide resuscitation in the event of a cardiac arrest.

So who has the final say when doctors and patients disagree, and what are the lessons for emergency physicians?

Lesson 1 — The need for education

Few members of the public understand the dismal prognosis of cardiopulmonary resuscitation (CPR). Deceived by images from television programs such as *ER* and *Chicago Hope*, many believe that resuscitation brings critically ill people back to perfect health. Few appreciate the risk of cognitive impairment and the quality of life associated with persistent vegetative states. When given accurate information, many patients who have expressed a desire for CPR change their minds.^{1,2}

Patients and families often believe that a DNR order means the medical team is giving up on them. This belief is an important and understandable factor in the A.S. case. In fact, many health care professionals mistakenly assume that “DNR” means “no intensive care,” “no intubation” or “comfort care only,” and there is evidence that some health care providers inappropriately withhold beneficial treatments from patients with DNR orders.^{3,4} Before we can reassure patients that “DNR” does not mean “abandonment,” we need to ensure that physicians and nurses are

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responding appropriately to DNR orders and that patients are receiving the desired level of care.

Lesson 2 — The problem with “futility”

Many physicians argue that CPR is not indicated for patients such as Mr. A.S. because it offers no benefit; it is “futile.” This loaded term is often used to convince patients and family members to forego CPR, or to justify giving physicians the right to impose DNR orders without consulting patients. In fact, the likelihood that an elderly person will return to a state of independent functioning after resuscitation ranges from less than 1%⁵⁻⁷ to as high as 10%,^{8,9} depending upon the study. When most physicians use the term “futility,” they are really saying that they believe the risk of persistent vegetative state or cognitive impairment is too great, or that the expenditure of resources is not worth the limited benefit anticipated. If the former is true, the issue becomes what each person considers an acceptable risk for himself or herself; if the latter is true, the issue is how we should allocate health care resources in our society. Either way, the issue is rarely “futility,” and physicians should stop framing it as such. It’s a deceptive practice.

Lesson 3 — Resource allocation decisions are difficult

The A.S. case appears to be about the appropriate use of societal resources. Even though Mr. A.S. and his wife feel that the small hope resuscitation offers is worth the cost, the physicians and institutions seem to disagree. They are putting a price on human life, and because this feels uncomfortable for them, they explain their concerns using terms like “futility.”

We are right to feel uncomfortable when economic considerations affect clinical decision-making. Physicians should see themselves as patient advocates first and resource managers a distant second. However, we also need to realize that the dollars used to delay Mr. A.S.’s death might be better used elsewhere.

Unfortunately, there is little reliable evidence to guide us through the process. Although many studies have attempted to identify patient characteristics that predict a poor response to resuscitation, their results are inconsistent and hard to generalize, and even when relevant evidence is available it is often ignored. For example, age-based limits are sometimes suggested for resuscitation yet there is evidence that, after adjusting for comorbidity, the elderly do just as well as younger populations.^{9,10}

Lesson 4 — The importance of communication

It is difficult to communicate clearly and compassionately in the emergency setting. While most of us recognize the importance of spending time with the family of a dying patient, other urgent problems often demand our attention. One of the factors that led to legal action in this case was a breakdown in communication between Mrs. S. and the health care providers. It is naïve to suggest that all ethical and legal problems can be solved by careful listening and empathetic communication; however, there is clearly a need to improve the quality of our discussions with patients and families, particularly as they relate to end-of-life issues. It would also help to have more staff available, to involve other team members such as social workers, and to improve the teaching of these areas in undergraduate and residency programs.

Conclusion

Courts should not determine who is an appropriate candidate for resuscitation. Fortunately, I don’t think it will come to this. The judge in the A.S. case has asked the participants to negotiate a settlement rather than to pursue a legal solution. Whatever the outcome, physicians must, in future, accept some of the responsibility for creating this problem, for solving it, and for preventing future problems. We must educate our patients and ourselves, we must stop hiding behind “futility,” and we must encourage our society to recognize the limits of resuscitation. What price are we willing to pay for ever-diminishing returns? More importantly, what stops us from communicating openly and honestly with our patients and their families about these difficult issues?

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Editor's note: I am often disturbed when I hear physicians discussing "code status" with their patients. Patients are typically given two choices (I paraphrase): "We can give you standard care and make you comfortable," or "We can shock your heart, put a tube down your throat, and have a machine breathe for you, but it might be very painful and you will probably end up a vegetable." The script is designed so that a reasonable patient would come to the (physician's) desired choice. In the area of resuscitation, physicians have clear perceptions of what is best, and while these may be generally reasonable, both in terms of the patient's best interest and what society can afford, they may not reflect the perceptions of the rest of society. Health delivery principles and societal expectations are moving toward a more "patient focused" model, but in this issue we seem to be clinging to the traditional "doctor-centred" approach. [G.I.]