GeriPal - Geriatrics and Palliative Care Blog

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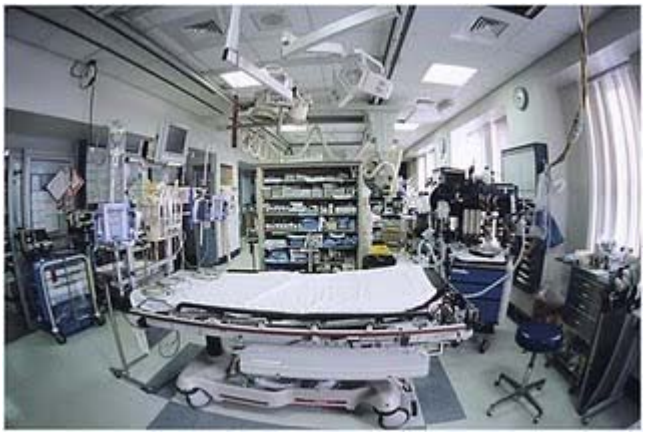
Monday, April 12, 2010

An ER Physician's Take on DNR Orders



It is a story that happens all too frequently in a fragmented healthcare system. A woman with cancer on chemotherapy codes in the emergency room. Nobody knows her code status. The ER physician uses the skill and talent gained from years of training to successfully resuscitate her. The family arrives to let the physician know that the women had a DNR order. After discussions with the women's oncologist and ICU team the family decided to not pursue dialysis and withdraw the ventilator. Disappointment sets in for the young physician as seemingly everyone gives up on his "save".

It is hard not to feel bad for everyone in this story as heard on today's NPRs morning edition. The woman who coded endured an ending to her life that she specifically asked to avoid. Her family had to both see the outcome of the code and be burdened by the resulting medical decisions. The ER physician, Dr. Boris Veysman, felt heartbreak that his efforts were not only in vain, but also

Welcome To GeriPal

GeriPal (**Geri**atrics and **Pal**liative care) is a forum for discourse, recent news and research, and freethinking commentary. Our objectives are: 1) to create an online community of interdisciplinary providers interested in geriatrics or palliative care; 2) to provide an open forum for the exchange of ideas and disruptive commentary that changes clinical practice and health care policy; and 3) to change the world. We aim to be inclusive. We welcome the perspectives of generalists, specialists, gerontologists, palliative care clinicians, and anyone else interested in care of the elderly or palliative care. Anyone who wants to comment on a post is welcome -- just click the comment

undesired by all. His frustration at the outcome of the women's case is palpable throughout this piece:

> She died peacefully several hours later. The best resuscitation of my career turned into my most memorable professional disappointment.

I don't blame Dr. Veysman for feeling this way. Blaming him would be akin to blaming the gas pedal for not braking. As an ER physician he did what he was supposed to do in this situation – resuscitate the patient if code status is unknown. What failed here is the advance care planning process in a fragmented healthcare system. There was a complete lack of a comprehensive approach to give patients their voices in emergent situations. I wonder how different things would have been if options like the POLST form was used in this case.

The lesson I learned from this essay is that resuscitation can be technically perfect yet fail the patient. This however, is a very different than the lesson Dr. Veysman gives his audience, which mostly falls in the simplistic don't "give up" advice. It may be helpful for us all to turn to one of Dr. Veysmans earlier works to give us some perspective (Ann Intern Med. 2004;141:76):

> If we are to let them go after so much has been done, were all our efforts in vain? So it often happens that we give birth to hope where there may have been none. But to the patients, that hope means more suffering.

Posted by Eric Widera

Labels: Advance Care Planning, End-Of-Life Care

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14 Comments:

Christian Sinclair, MD said...

Dr. Veysman has gotten a lot of mileage out of this story. First it was published in Health Affairs and noticed by Joanne Kenen at New America who alerted me to it. Then a different version appeared in the Washington Post. And now a narrative on NPR.

I wish I could milk/repurpose content that well. That is probably the biggest lesson I have taken from Dr. Veysman. As far as his opinions on 'Don't give up' his longer form articles really border on parentalistic based on his 'one time a guy walked out of my ED alive with the same thing you have' version of the availability heuristic bias.

His original Health Affairs articles has several statements I disagree with which i think Kenen's piece dealt with very well. He also describes what he wants which is clearly a very aggressive approach but I think he needs to be cautious about imposing that on his patients.

But don't take my word for it, go read the Health Affairs piece. It is very deserving of a letter to the editor if anyone would like to collaborate.

BTW I have emailed him to let him know about the post if he wanted to contribute.

April 12, 2010 10:33 PM

Celeste said...

When I read this, my initial thought was just what Dr. Sinclair wrote, "Dr. Veysman sure has gotten a lot of mileage out of this."

From my perspective reading this article in it's various forms (I saw one where the sex of the patient had been changed to male, but it was the same story and same author), I believe Dr. Veysman likely has very limited experience working with people though the dying process (more than the very limited adrenaline loaded process that one sees in the ED). He suggests that all of these patient's symptoms can be fixed (the

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Medicare reimbursement is likely the reason why most heart failure teams are based in outpatient settings. Unless there is an acute episode, the...
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I think a heading titled "Submissions" or "Contact" would make it a lot faster to learn the procedure. It took me a while to find...
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Dan Matlock wrote...
One of my mentors uses this figure when he lectures on advocacy. Alex, I'm not quite sure what the answer to your question is as I think more...
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Anonymous wrote...
Perhaps the societal and political perspectives on Dr. Smith's questions are separate from the individual doctor's perspective. That is,...
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Anonymous wrote...
That guy must have had an interesting personality, because that is precisely why death is so scary to most people-- the unknown is scary-- it allows...
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Eric Widera wrote...
My favorite line by a patient when asked if he was afraid to die:Death is a mystery. Why whould I be afraid of a mystery?

ken covinsky wrote...
thanks for the comments Chris, Dan, and Eric. A few thoughts:I think Chris illustrates an important reason why health-related quality of life scales...
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Dan Matlock wrote...
I agree with anon that this inner peace isn't an option for

depression, weakness, loss of appetite, malnutrition). Although we do have pharmaceutical agents to address all of these problems, anyone who has worked with dying patients realizes that there are times when they have no benefit. Likewise, dialysis, if one could find a nephrologist willing to do it, is not a procedure without it's own side effects.

Press like this isn't helpful. It suggests that all of life's problems can be magically fixed.

April 13, 2010 4:16 AM

Eric Widera said...

Thanks Christian. This essay certainly has some legs. I'm guessing it is because there is an undercurrent of public sentiment that agrees with Dr. Veysmans point of view. Or maybe publishers like it because it is provocative?

I find the longer version in Health Affairs much more distressing than the NPR story. It gives me the impression that the author is trying to convince us that what he did was right by adding modifiers to certain aspects of the case. We hear that this women has "only mild evidence of metastatic cancer" instead of just saying she has metastatic cancer (what is mild evidence anyway?). Her symptoms from chemo and cancer were only "minor symptoms" - were they really minor to the patient? She is "doomed" tomorrow only if the family refuses dialysis, never mind that she just coded, has an organ down, and has had weakness, anorexia, dehydration, and malnourishment secondary to metastatic disease.

I understand how emotionally upseting this must feel to the author. His end-of-life preferences are very different than this patient's preferences. But, I can't help feel a lack of respect for the oncologist, the family, and most importantly, the patient. How and when does her previous wishes come in to medical decision making?

April 13, 2010 9:27 AM

Eric Widera said...

Thanks also to Barbara Brown for emailing me about this article.

April 13, 2010 10:10 AM

Helen Chen said...

I listened to the piece on NPR and found it very upsetting as well and stunning that we still have physicians who believe only THEY know what's best for patients. Perhaps the patient would have had "a few more good weeks" but I think we have all seen the opposite--patients with terminal conditions who choose aggressive tertiary/quarternary care (which I would absolutely support if that is their choice) and end up having only a few more very horrible weeks or even days. Medicine can't fix everything. Palliative medicine, sadly, can't fix everything either, but what we can do is help patients achieve their own goals for their own care.

April 13, 2010 6:15 PM

Marian Grant said...

I recently had to send a pt with end-stage lung cancer from my in-pt hospice to the ED as he was full code and asked to go. Fortunately, a wise ED physician took one look at him, called his oncology and together they persuaded the pt and family that enough was enough. He was back in our hospice 3 hours later and died a couple of days after that, comfortably, with family around him. A blessing for all involved, thanks to the ED!

April 13, 2010 6:18 PM

Eric Widera said...

For another take on this piece check out Rogue Medics post titled "Shock Me, Tube Me, Line Me".

April 13, 2010 8:45 PM

Lynn said...

This is why they should have valet parking at all hospitals.

April 13, 2010 9:13 PM

Dan Matlock said...

If you go into medicine to save lives, you will eventually fail 100% of the time

April 13, 2010 9:34 PM

Lynn said...

All joking aside, I remember feeling very uncomfortable when I read this article in Health Affairs. The author did nothing more than demonstrate his own arrogance and his disrespect for this patient. And he claims she was the one who

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9 days ago

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Who is GeriPal?

GeriPal was founded by Eric Widera and Alex Smith. Contributors include Bob Arnold, Ken Covinsky, Anne Johnson, Bree Johnston, Helen Kao, Chrissy Kistler, Leslie Kernisan, Sei Lee, Susan Lysaght, Dan Matlock, Carla Perissinotto, VJ Periyakoil ,Mike Steinman, Rebecca Sudore, Brad Stuart, Paul Tatum, Ori Tzvieli, Patrice Villars, and Ron Walent.

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made his night "interesting." I shudder to think of how the "usual strokes, heart attacks and bleeding ulcers" were treated.

April 13, 2010 9:36 PM

Jenn Jilks said...

It is time that ER physicians respect the patient. And all physicians listen to patients. That said, patients must let family know their wishes, whether they agree or not. Too many end up dying in an ER, when this is expressly against patient wishes.

April 14, 2010 6:30 AM

Rogue Medic said...

Dr. Widera,

Thank you for the link and for bring attention to this.

I think that Dr. Veysman means well, but that he does not realize his own limitations.

I think that is part of what has made this article so appealing to so many of us. We want to be told that that doctors can handle anything. That we will be resuscitated. That anything is possible with a positive attitude. *I swear on my autographed copy of* ***The Secret***.

This is the same thing that is behind so many of us going to alternative medicine practitioners. We will engage in all sorts of self destructive behaviors, *if we get the right sales pitch*.

Reality is so much less appealing to deal with.

Dr. Sinclair should not ridicule my availability heuristic bias. Availability heuristic bias is my friend. Availability heuristic bias helps to shelter me from reality. At least until I can't hide from reality any more. ;-)

PS I love the research done by Dr. Kahneman and the late Dr. Tversky. While it might be nice to assume that we are rational, they have provided us with abundant evidence that we must constantly work to overcome out irrational tendencies.

April 14, 2010 9:16 PM

Alex Smith said...

Ethics New Old Age cancer mammography AAHPM Advocacy Americas Best Hospitals Annals of Internal Medicine Ashwini Sehgal CPR CancerPEN Community Emergency Department Falls Forgiveness Functional Impairment Futility Healing International Internet Newsweek PACE POLST PTSD Paula Span Social Work Teaching Video american academy of neurology cardiology death depression devices doctor driving drug monitoring insomnia insulin interpreters life-support medical home medicare medicine mental health palliators' network patient patient safety post-traumatic stress quality of life research methods sense of purpose substance use translation veterans warfarin

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When I conducted focus groups with emergency providers, attitudinal barriers to providing palliative care in the emergency department were an important theme. One of the emergency medicine physicians stated:

This is an overgeneralization, but I think that palliative care has
a little bit of a negative connotation in the ED. If you think
about people who go into emergency medicine, they want tosort of act and do, cure. When someone comes in and their status is DNR or comfort care, it is not necessarily seen as a priority or as a good thing. The first reaction is almost "Why are they here? Why are they bothering us? This is not an emergency."

Another attending noted that the goals of the physician in going into emergency medicine (desire to provide life-saving care for many) should not enter into clinical decision making. The focus should be on the patient in front of you.

Nurses in the emergency department described the importance to them of providing quality care for dying patients in the ED.

Attitudinal barriers exist, but there are also champions for palliative care in the ED. The key is to work with emergency providers to improve care for patients with serious and terminal illness and their families.

April 15, 2010 12:45 PM

David Tribble said...

I found the language troubling - it was centered more on the ER physician's personal accomplishment (or at least his view of an accomplishment) than it was on whether he had met the patient's needs (...The best resuscitation of my career turned into my most memorable professional disappointment...). A POLST form might certainly have avoided the resuscitation, but so might a sober consideration of the status of the patient. Most physicians I know, even ER docs, would be apologetic to families of patient they had put through a resuscitation because they did not know the advance directive, not angry because their good work was wasted.

This wasn't about the physician. It was about the patient.

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