Continue CPR! or How to Save the Patient and Screw the Pooch[1]

JOHN SHUFELDT, MD, JD, MBA, FACEP

So there I was (all good stories start this way), having just participated in saving a 58-year-old guy who collapsed while playing golf with his buddies. It was a classic v-fib arrest—dropped after hitting a great drive right down the middle of the fairway. The man's friends started CPR, paramedics arrived and shocked him out of VF into a sinus rhythm and intubated him.

While in the emergency department (ED), the man started waking up; he was reaching for the tube and seemed to be following commands. I had already arranged an ICU bed for him when a woman claiming to be his wife ran into the ED and screamed, "Take that tube out immediately; he has a DNR" at the top of her lungs.

Although the patient was waking up, it was still way too early to extubate him. In my very gentle, Marcus Welby-like voice I said, "Ma'am, your husband is alive and, considering what happened to him, doing great. We expect him to wake up and have minimal or no cognitive impairments. However, if we remove that tube now, we may completely wreck his chances for a complete recovery."

Her response was less than encouraging: "If you don't pull that tube immediately, I'll have your a** and your medical license." How nice, she wants me for my mind too! I'll spare you the details, but the story actually gets worse from here. We actually did extubate him about 10 hours later. His first words? "I want a cheeseburger!" His wife? An RN; this was her fifth marriage and her first four husbands all died. Can you say Black Widow? She filed a complaint with the medical board about me saving her husband.

The reason I did not simply yank the patient's tube when she shoved the DNR papers into my face was my belief that I could get sued if I killed him but no one would successfully sue me for saving him. Until recently, that belief held true. (More on that later.)

Why does this matter in to an urgent care provider? Every day, 7,000 people–yes, 7,000—enroll in Medicare. Odds are great that with all of us "baby-boomers" hitting retirement age, some of us will decide to spice up your day and die in your urgent care center. So, listen up, because unless you have a pediatric urgent care practice, this is relevant to you.

First, some background. A number of legal or quasi-legal documents fall under the term "advanced directive." Generally speaking, advanced directives are written to provide some direction regarding end-of-life care for a patient who may not be able to give medical consent or direction. They fall into the following categories:

DNR Order

Controversy exists surrounding the interpretation and execution of do not resuscitate (DNR) orders. For example, does "DNR" mean do not treat up to the point the patient requires resuscitation? Or does it mean once the patient codes, everything stops? Some newer forms are more specific, using check boxes to delineate the level of care acceptable to the patient. On the surface, that makes sense, but practically speaking, these forms are still challenging to use. If a person checks no intubation and suffers a short-term event (seizure) and needs to be intubated, do you let him/her die? If "no defibrillation" is checked, does that mean no AED in the case of sudden death? What if the patient is still conscious and can make decisions and wants "everything done"? Do you quit when he/she becomes unresponsive? Because of all these common potential pitfalls, many institutions now use a "limitation of treatment form." Take-home point: When faced with one of these situations, misery loves company. Get the family involved at the outset and document the decision made together.

John Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*. He may be contacted at *Jshufeldt@Shufeldtconsulting.com*.

Urgent care physicians and emergency physicians are in no way restricted from performing lifesaving interventions on patients with living wills, inasmuch as we won't have the opportunity to confer, at least prospectively, with the attending physician.

Pre-hospital Directives

Most states have instituted some form of an advanced directive upon which paramedical personnel can rely when erroneously called to treat a critically ill or injured patient. These can be physician-driven DNR-like documents or a patient- or surrogate-driven advanced directive. Their implication for urgent centers is negligible, save for a patient or family attempting to use one in the "pre-hospital" urgent care arena.

Living Will

A living will is a fairly standard form used in most states to direct health care workers to not perform or to perform certain medical interventions. Any competent person 18 years of age or older can author a living will by signing and dating a statement before two witnesses. The witnesses must be at least 18 years old, and should not be related to the person signing the declaration, a beneficiary of his or her estate or financially responsible for his or her medical care.

A living will only goes into effect once an individual lacks the capacity to make health care decisions and it lasts until he/she has the capacity for decision-making. Living wills vary in specificity but often include interventions such as:

- CPR
- Defibrillation
- Intubation
- Artificial nutrition
- Antibiotics
- IV fluid
- Analgesia

As mentioned, a living will can be very specific or very general. The following is an example of a statement sometimes found in a living will: "If I suffer an incurable, irreversible illness, disease, or condition and my attending physician determines that my condition is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued."

The key to this statement is "my attending physician." Thus, urgent care physicians and emergency physicians are in no way restricted from performing lifesaving interventions on patients with living wills, inasmuch as we won't have the opportunity to confer, at least prospectively, with the attending physician.

Durable Power of Attorney

Finally, individuals can make a prospective decision about who can act as a surrogate if they become incapacitated. This generally allows for more flexibility because the surrogate can make decisions on behalf of an incapacitate person that the patient would ordinarily make. Obviously, you have to trust the person you appoint. Case in point: A friend of mine from medical school called me not long ago and asked if I would act as his medical power of attorney. I replied, "Of course, but what about your wife Tracy?" He responded, "That b&^* would cut off my testicles and only then take me off the ventilator!" Fearing that they had split up, I inquired as to Tracy's whereabouts. He responded, "She is right here, want to speak with her?"

What if no durable power of attorney exists? What is the chain of command regarding who can decide the fate of the patient? In Arizona, the decision-making hierarchy goes like this: Patient's spouse, unless legally separated > adult child of patient > domestic partner > siblings > close friend > attending physician with ethics committee.

How making the wrong decision will get you sued

You are working in an urgent care center when a patient presents with the complaint of constipation. You learn that the patient has gastric cancer and is on very large doses of opiods, which are the likely cause of the current issue. The patient is obviously terminally ill but is very uncomfortable secondary to his fecal impaction. You take a KUB to confirm your suspicion and check for free air. As you get your gloves on to disimpact the patient, he becomes very bradycardic and ultimately codes. The family member is unsure of the patient's code status but tells you, "He is very religious and probably wants everything done." Using "substitute judgment" and because the family member hedges on the code status, you elect not to try to resuscitate this obviously terminally ill patient, telling the family member, "In good conscious, I simply cannot do this to him."

The surviving family members decide to sue on the "loss of a chance" theory. Their suit alleges that you failed to promptly initiate appropriate care to treat the decedent's cardiac arrest and that this negligence deprived the decedent of the loss of a chance to survive. The Iowa Supreme Court

recently recognized an action for loss of chance in a terminally ill cancer patient whose resuscitation request was not honored by the physician.

Getting back to the Black Widow

So what changed? There have been a number of suits alleging "wrongful life." In Florida, a 92-year-old patient's granddaughters filed suit against a nursing home and medical director, alleging that they committed battery against their grandmother when they failed to follow her DNR order after she coded. In addition, the lawsuit, which sought unspecified damages, alleged that the medical director decided to send the patient to the hospital rather than follow her DNR order because he was not at the nursing home at the time she collapsed. The paramedics performed CPR and intubation, and transported the patient to a hospital. There, she was on life support for 3 days and died 4 days after life support was discontinued.

In another case, a patient was admitted to the hospital for chest pain. The attending physician, after a discussion with the patient, wrote that the patient was not to be resuscitated. At one point during his hospitalization, he went into v-fib and was cardioverted by the nurse. The patient survived the event and even thanked the nurse. Four days, later he suffered a massive stroke; he ultimately died a few years later. The family sued, alleging that the nurse's actions constituted battery and that the nurse was negligent in not following the physician's orders.

Epilogue

Eighty-five years ago, Justice Benjamin Cardozo wrote, "Any human being of adult years and sound mind has a right to determine what shall be done with his own body." This right of self-determination is evidenced legally in the form of consent, before any diagnostic or therapeutic measure is instituted. For the consent of the patient to be legally valid, the consent must be given after the patient has been fully informed about the proposed treatment. In other words, the consent must be informed consent. Once the consent is obtained and it is valid, a provider, whether he or she agrees or not, is legally obligated to follow the patient's wishes.

If faced with a life-or-death scenario, do your best to determine the wishes of the patient or surrogate, if one exists. Document your attempts to determine these wishes. If you cannot, use substitute judgment to determine the plan. Despite the "wrongful life" cases, if I had to do it again, and did not know the wishes of the patient, call me old fashioned, but I would err on the side of saving a patient's life. ■

1. The phrase "screw the pooch," meaning to mess up, commit a grievous error, was made famous in Tom Wolfe's book *The Right Stuff*.