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Anaesthesiology's palliative care challenge

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Summary

"*Patients don't want futile care, including CPR and they do want Palliative Care. Since CPR is highly ineffective and futile in patients dying of non-cardiovascular diseases, it no longer has a role in routine hospital care. Palliative Care procedures that require general anaesthesia should not require the cancellation of DNR orders since only CPR is being limited. As Clinicians we must accept that the only requisite for life is death and that providing Palliative Care at the end of life is our clinical obligation and privilege*".

In 2006 in the midst of a protracted futile care crisis, I wrote: "Since dividing by zero defines infinity and the benefits of futile care are zero, a costs/benefits ratio analysis of futile clinical care reveals its costs are infinite." [1] I also noted a quality of care definition and the clinical deficiencies of DNR policies. The question now is: "Is less futile care being provided?" The answer is 'Yes' but for unforeseen reasons.

Most clinicians still practice as if death is always preventable and many continue to recommend clinical interventions for specific medical conditions without regard for the underlying general medical conditions even when death is imminent! In addition, the quality of care issues is still unaddressed and DNR policies remain as deficient as ever. So, why are clinicians not providing as much futile care as they used to? What changed?

The decline in futile care today is due to patients and surrogates frequently choosing to forgo 'life-prolonging', a.k.a. futile, medical interventions and readily accepting DNR orders. They have seen their families and friends suffer from CPR and these interventions before dying and they do not want this for themselves. In general, Patients and their Surrogates not wanting futile care is leading to less being provided. This was unanticipated.

Fortunately, these circumstances have facilitated clinicians' end-of-life discussions. Since wholesale changes in DNR policies are not in the offing, Clinicians must modify their approaches to the end-of-life decision-making and then provide Palliative Care.

Palliative, i.e., End-of-Life, Care emphasizes quality (rather than quantity) of life. Not infrequently, palliation involves procedures requiring general anaesthesia. Unfortunately, most Anaesthesiologists have not come to terms with Palliative Care and DNR orders and usually require the 'cancellation' of DNR orders before agreeing to provide general anaesthesia. This is clinically misguided and needs to be updated. The rationales for these updates are as follows.

[1]Preposterously, CPR remains the only medical intervention that requires a Clinician's order NOT to deliver, i.e., a DNR order.

CPR: Highly ineffective, frequently not medically indicated and obsolete

Cardiopulmonary Resuscitation (CPR) was invented in the late 1960's [1] and declared a 'Standards'[2] in 1974 during a widespread 'epidemic' of heart attacks and cardiac arrests in middle-aged men with coronary artery disease. At the same time, interventions like coronary artery bypass surgery (CABG) were becoming increasingly available. CPR was seen as saving many of these men's lives. Regrettably, CPR has been highly ineffective. In field 30-day CPR survival rates are mostly in the single digits and in hospital CPR survival results are not much better.

Tragically, since 1974 in the absence of a DNR order, CPR has been automatically delivered to ALL patients (not just middle-aged men!) who suffer cardiac arrests [2]. This is without any data for CPR's effectiveness in the elderly, women and patients dying from other diseases such as cancer, kidney failure, strokes, lung diseases, etc.[3]

Basically, CPR is not medically indicated and is universally futile in patients dying from non-cardiovascular diseases.[4]

Currently, acute myocardial infarctions (AMI) are uncommon. Prevention and early interventions before AMI and during AMI have worked. Thus, the rationale for CPR is gone and, since it is also highly ineffective and misapplied, CPR should no longer be widely provided. It is obsolete. The only plausible reason for its continuation outside very limited and defined situations such as cardiac catheterization lab is the massive revenues it generates its perpetuators.

'Clinician do not do only harm'

The mantra, 'Physician, Do No Harm', is universally misunderstood. Anything a Physician or Clinician does or fails to do is potentially harmful. Almost all medical treatments and interventions have death as a possibility and many have well documented temporary and some

[2]The tragedy in these circumstances was frequently not that the patients died, but that some patients were resuscitated only to die again! Many a 'plug has been pulled' after 'successful CPR.'

[3]Even though cardiovascular disease is the most common cause of death it should be noted that in the vast majority the underlying cardiac disease is irreversible and inevitable. Therefore, CPR is only death-prolonging and not life-saving.

[4]Regulatory and Accreditation Organizations may need to change their reporting requirements to accommodate general anesthesia for palliative procedures.

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permanent harms ('complications' and 'side effects'). Ironically, almost all surgeries cause pain, i.e., harm, as a direct effect. Why risk or do harm then?

Clinicians risk or do harm because the benefits significantly outweigh the risks of harm. For example, about 3 out of 100 patient undergoing coronary artery by-pass surgery (CABG) die. Why do CABG's? A 3% death rate for CABGs is acceptable because 97% benefit. Innumerable patients with atherosclerosis benefit from daily aspirin therapy even though a very small minority die from bleeding complications. And as noted above, CPR seems to do mostly harm.

Thus, the correct mantra is "Clinician, Do Not Do Only Harm" benefits must significantly outweigh risks.

Palliative care procedures and DNR orders

According to the 1974 Standards[2], the 'R' in DNR means CPR. CPR includes Basic Life Support (BLS) and Emergency Cardiac Care (ECC) both delivered in event of a cardiac arrest. Nothing in a DNR order, should prevent cardiac or other care interventions including endotracheal intubation and mechanical ventilation in the absence of cardiac arrest. Thus, automatic 'cancellation' of DNR orders for modern general anaesthesia is unnecessary.

So, what if the patient suffers a cardiac arrest and dies pre-, intra- or post-operatively. In these very rare circumstances, the patient should be allowed to die in peace like they would have been during there regular unit care. The 'OR" is not a magical place where patients can't die!

Personally, I have experienced a patient's death during bronchoscopy for palliation of cancer-related massive haemoptysis. It was unfortunate and even though bronchoscopic palliation was 'a long shot', it was considered reasonable palliation. Even though I felt horrible, I respected the patient's wishes not to provide CPR for his terminal disease. I fulfilled my clinical (fudiciary) obligations to the patient.

Requiring the cancellation of DNR orders for the benefit of the clinician and not the patient negates their fiduciary responsibilities to their patients. If a clinician cannot accept death as a possible outcome, then they should decline to participate in the procedure. Nevertheless, patient must never be abandoned and unable to receive medically necessary palliative care.

References

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