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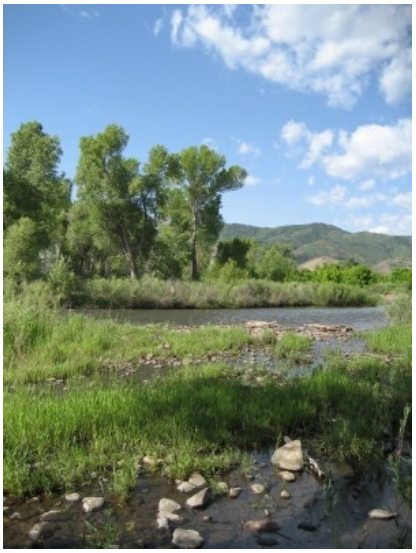
## Hospitalist Update



### Do physicians impose clinical care decisions with life and death implications on patients without their knowledge and consent?

William Steinmann MD

*A 90 year old woman has been discharged for an expected short stay at an intermediate care nursing facility for physical therapy in order to regain her baseline functional status. Her hospital diagnoses were community acquired pneumonia complicated by new onset CHF, triggered by excess IV fluids; both conditions were treated successfully. Though blind from glaucoma, she is not cognitively impaired. She has a pacemaker for sick sinus syndrome but no history of coronary artery disease. Prior to this admission, she has lived a relatively independent life in an assisted care facility; she, her family and her PCP all expect her to return there after rehabilitation.*

*Upon arrival at the nursing facility, the attending physician (who has never seen this patient before) suggests that she consent to a DNR status. He does this based on limited information from his own H&P and the hospital discharge summary; he does not consult the patient or her family members regarding her previous independence, health status prior to admission and her plans for the future. He ignores the fact that the patient was not DNR during the hospitalization, even when facing life-threatening conditions.*

The above case represents what may be an increasingly common problem: decision making by specialists (including hospitalists) who are less informed than the patient's PCP regarding his/her overall clinical status, prognosis and personal wishes. Yet, such decisions may prove critical in future management, and may not be in the patient's best interest. Even worse, this decision making process may reflect an insensitivity (if not cavalier attitude) by care providers toward these patients, who may be facing the most important decision of their lives.

Unbeknownst to the patient and her family, the assignment of a DNR status can influence the level of diagnostic and therapeutic care that she receives during her stay. Beach and Morrison (2002), among others, have shown that DNR orders can lead to inadequate testing and therapy; simply stated, DNR may be interpreted as "do not treat. In the case of our patient above, what if she develops respiratory difficulties

(cont) secondary to sleep or pain medication or, perhaps, recurrence of her CHF due to a failure to restrict her salt intake? With the DNR order in place, expectations regarding her prognosis and recovery may be lowered and the response to her symptoms may be less aggressive than might be considered the standard of care in non-DNR patients. In such cases, despite expectations by the patient, her family and her PCP, medical decision making may be clouded and the DNR status might actually contribute to her death.

Perhaps even more pernicious are situations in which a patient's chronic conditions (such as CAD and CRF), though well controlled prior to the hospitalization, are exacerbated by acute medical problems or by iatrogenic factors (e.g. volume overload). Hesitant to initiate aggressive therapy in an elderly patient with serious chronic medical conditions, the attending physician suggests a DNR status and, if agreed to, uses that consent to become lax about routine management and to forego interventions such as dialysis. If, on the other hand, the patient's acute problems are treated aggressively, he might recover completely and return to his previous level of functioning.

These common but unrecognized practices have tremendous implications for patients and their families. Whether intentional or not, clinicians may be making judgments that are based on cursory information and are often not in the best interest of the patient. While the reasons for such actions are not clearly defined, it is likely compounded by the increasing role of specialists and hospitalists in the care of inpatients, when they are most vulnerable and when input from their PCP and family may not be immediately available.

It is important that hospitalists recognize the full implications of actions that they take and decisions that they make on behalf of the patients that they serve. As patient advocates, we must make every effort to understand the true wishes of the patient and their family and take the time to discuss their baseline functional status with their primary physician prior to initiating any care restrictions. Patients and their families must also be educated regarding the potential implications of a DNR order and should be encouraged to share their views regarding any limitation of care. Above all else, we must come to appreciate our own innate biases and resolve to distinguish DNR from Do Not Treat.

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**HOSPITALIST CONFERENCE & LUNCHEON**

MISSOURI ACP MEETING

SATURDAY, SEPTEMBER 26, 12:15 PM

TAN-TAR-A RESORT, LAKE OF THE OZARKS

TOPIC: HOSPITAL ACQUIRED INFECTIONS

http://www.acponline.org/meetings/chapter/mo-2009.pdf