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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

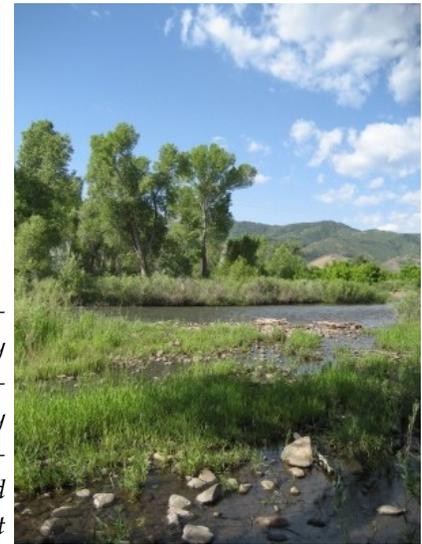
A 90 year old woman has been discharged for an expected short stay at an intermediate care nursing facility for physical therapy in order to regain her baseline functional status. Her hospital diagnoses were community acquired pneumonia complicated by new onset CHF, triggered by excess IV fluids; both 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



Inside this issue:

Hospitalist Update

Case of the Month

From the Journals

ID Corner

Calendar

Comments

(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.

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>

CASE OF THE MONTH

LES HALL, MD

A 20 year old male was transferred to UMH for ongoing treatment of atypical pneumonia. One week before transfer, he had developed fever, chills, sweats, malaise, a minimally productive cough and shortness of breath. The CXR revealed a diffuse interstitial reticulonodular pattern. When he failed to respond to levofloxacin, he was placed on vancomycin and piperacillin-tazobactam and referred for further evaluation and management.

He denied past medical problems. Having emigrated from the Marshall Islands in 2008, he had been living in Missouri over the past year. He denied sick contacts, recent tick bites or significant exposure to animals. He reported smoking 5 cigarettes per day. Initial labs revealed a WBC of 4100, with normal Hgb, Hct and platelet count. Renal function was normal but the liver transaminases were mildly elevated: AST 136, ALT 123.

Azithromycin was added as a third antibiotic. Fever and subjective symptoms initially improved but his temperature spiked to 39 C one week after admission. Sputum was negative for common respiratory pathogens, AFB and fungi. PPD was nonreactive. Lab screens for Ehrlichia, Legionella and HIV were negative; fungal serologies were also negative. His LFTs normalized within days of admission and blood cultures remained negative.

Bronchoscopy revealed micronodular changes in his airways but bronchial washings were negative for AFB and fungi. However a transbronchial biopsy revealed caseating granulomas with AFB positive organisms, consistent with miliary TB. Eye exam revealed evidence of TB choroiditis and the patient was started on 4 drug therapy for TB. Over the next few days, his fever resolved and he was discharged to complete an outpatient course of anti-TB therapy, as recommended by our ID consultants.

Discussion: Relatively rare in the U.S., miliary TB is often not seriously considered in patients with a febrile illness until other infections are excluded. Although this patient's illness did not appear to be life threatening, those with more severe symptoms should be covered with empiric therapy until tissue diagnosis is obtained.

This case reminds us that, although TB continues to slowly decline in the U.S., it is still a prevalent disease worldwide, with a disproportionate share of illness in foreign-born individuals (1). Since the Marshall Islands have a current population of just over 60,000 individuals, most U.S. health care workers do not regularly encounter emigrants from that nation. However, the incidence of TB in the Marshall Islands has been increasing in recent years (2), with a prevalence of 281 cases/100,000 population (compared to a median U.S. prevalence of 3/100,000). This case also illustrates that a negative PPD does not exclude TB, even in patients presumed to be immunocompetent. Further investigation revealed that this patient had a positive PPD (30mm) one year ago, at the time of his emigration; even so, he did not receive treatment for latent TB. Finally, this case also raised significant infection control questions after the diagnosis was established; i.e. did hospital infection control personnel and public health officials need to complete a rigorous epidemiologic investigation of the patient's contacts? Miliary TB is considered a form of extrapulmonary TB (3); the CDC states that persons with extrapulmonary TB are usually not contagious unless they have concomitant pulmonary involvement, have disease located in the oral cavity or larynx or have disease that involves an open abscess or lesion (4).

1. Trends in tuberculosis—U.S. 2008, MMWR, March 20, 2009; 58(10): 249-253
2. WHO Report on TB in the Marshall Islands

http://apps.who.int/globalatlas/predifinedReports/TB/PDF_Files/mhl.pdf

(references continued on page 4)

3. Golden MP and Vikram HR, Extrapulmonary tuberculosis: An overview, *Am Fam Phys*, 2005; 72(9):1761-8
 4. Guidelines for preventing the transmission of *Mycobacterium tuberculosis* in health care settings. *MMWR*, December 30, 2005; 54(RR17): 1-141
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FROM THE JOURNALS

Robert Lancey MD

Yandiola et al., *Prospective Comparison of Severity Scores for Predicting Clinically Relevant Outcomes for Patients Hospitalized with Community-Acquired Pneumonia*, *CHEST*, June 2009; 135(6): 1572-1579

<http://www.chestjournal.org/content/135/6/1572.abstract>

A new severity score for hospitalized patients with CAP, the Severe Community-Acquired Pneumonia (SCAP) score, was found to be superior in multiple measures when compared with PSI and CURB-65.

Cantor et al., *Routine Early Angioplasty after Fibrinolysis for Acute Myocardial Infarction*, *NEJM* 2009, June 25; 360(26): 2705-18

<http://content.nejm.org/cgi/content/abstract/360/26/2705>

Over 1000 AMI patients who were treated with fibrinolysis were randomized to early PCI or standard treatment. Those who underwent early PCI had a significant reduction in major endpoints (death, reinfarction, CHF, cardiogenic shock) at 30 days (11% vs. 17.2% in the standard treatment group).

Zier et al., *Surrogate Decision Makers' Responses to Physicians' Predictions of Medical Futility*, *CHEST*, July 2009; 136(1): 110-117

<http://www.chestjournal.org/content/136/1/110.abstract>

This small but powerful study out of San Francisco gives an interesting perspective on the attitudes of surrogate decision makers toward physician recommendations about their critically ill family members.

ID CORNER

William Salzer MD

Management of Herpes Zoster:

Whitley, Richard, **A 70 year old woman with shingles. Review of Herpes Zoster**

JAMA series: Clinical Crossroads

JAMA 2009; 302: 73-80

Online version not currently available without subscription

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MISSOURI HOSPITALIST CALENDAR

Fundamental Critical Care Support 2009, Boone Hospital Center, Columbia, MO, August 7-8; contact Judy Feintuch, CME Coordinator, 573-815-3498; **LOCAL**

19th Annual Conference, Caring for the Elderly, Missouri Association of Long-Term Care Physicians, August 21-22, Holiday Inn Select Executive Center, Columbia; call 573-882-0366 or visit the CME website at www.som.missouri.edu/CME; **LOCAL**

Advances in Management of the Critically Ill Patient, Washington University, St. Louis Marriot West, September 12, <http://cme-online.wustl.edu>; **LOCAL**

Missouri ACP Meeting, September 24-27, Tan-Tar-A Resort, Lake of the Ozarks; Hospitalist Conference Luncheon on Saturday, September 26, 12:15 pm; topic: Hospital Acquired Infections; see ad on page 2 of this newsletter. **LOCAL**

Hypertension & the Cardiometabolic Syndrome, October 15, 2009, Hampton Inn & Suites, Columbia, MO, University of Missouri Department of Medicine, call 573-882-0366 or visit www.som.missouri.edu/CME; **LOCAL**

CHEST 2009, October 31-November 5, San Diego; information and registration online at www.chestnet.org

The Academic Hospitalist Academy: Essential Skills for Education, Scholarship and Professional Success, Society of GIM, November 8-11, Atlanta, Peachtree Conference Center; for more info, contact Amy Woodward, woodwarda@sgim.org

Please direct all comments, ideas and newsletter contributions to the Editor:

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