Alaska State Medical Association

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March 19, 2012

Honorable Hollis French
State of Alaska
Senate
Chair, Senate Judiciary Committees
State Capitol Room 417
Juneau, AK 99801

RE: SB 172 – Health Care Decisions and Do Not Resuscitate Orders

Dear Senator French:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

Thank-you for the opportunity to testify on SB 172 which pertains to health care decisions and do not resuscitate orders.

ASMA urges you not to make any changes in the current law which has been termed Alaska's Health Care Decision Act until you have thoroughly explored all material aspects of this very complex subject. A bill of this complexity introduced in the second 90 day session of a two year Legislature cannot be properly addressed in the time allocated and available. SB 172 deals with death, dying and end of life care, all of which our society for the most part abhors discussing.

It is estimated that only 20% of us have adopted advance directives that document our decisions as to when and how our end of life care is provided. The other 80% of us, leave these decisions until we are gravely ill when decisions are made in an environment that is highly emotionally charged; and often are made by surrogates who may or may not know what care we desired. These decisions are as well guided by closely held personal beliefs, religious tenets, and cultures.

Physicians providing end of life care are an integral part of this decision making process and responsible, first and foremost to the patient. In providing their counsel they are guided by their medical expertise and by their code of ethics (The Principles of Medical Ethics of the American Medical Association which are adopted in AS 08.64, see AS 08.64.326(a)(11), and 12 AAC 40.955 (a)). A physician who violates this code of medical ethics is subject to disciplinary action.

SB 172 (and the work draft seen by ASMA for a committee substitute) provides for the impossible situation for physicians of either violating provisions of SB 172 or violating the AMA's Code of Medical Ethics and thus violating the Alaska State Medical Board's disciplinary statutes.

ASMA understands that Alaska's current Health Care Decision Act was patterned on and closely follows the Uniform Health Care Decision Act drafted by the National Conference of Commissioners on Uniform State Laws. The uniformity benefits the people when they travel from one state to another. It would appear that uniformity would be disrupted by SB 172.

SB 172 would provide a "one size fits all proscription for advance health care directives which is not appropriate for all medical situations that can present. Attached is a very recent article that provides an interesting discussion of the potential "default options". ("Time to Revise the Approach to Delivering Cardiopulmonary Resuscitation Status", Journal of the American Medical Association, March 7, 2012.) This article infers that much more discussion is needed. (Also please note that the 20% of those estimated to have enacted advance directives in Alaska, should SB 172 be enacted, would need to have their personal attorney examine their existing advance directives and modify them if required by this proposed bill.)

SB 172 will impact every Alaskan and every aspect of it needs to be thoroughly addressed by the Legislature. ASMA does not believe that the required and warranted attention can be given to the varied and complex issues in the less than 30 days remaining in this session. To do otherwise, can be a result fraught with unintended consequences most of which could be expected to adversely impact the patient/physician relationship and the care provided.

ASMA stands ready to assist you in forming a group representing various stakeholders to examine all of the pertinent issues in a manner that "first does no harm".

Sincerely,

Mary Ann Foland

By: Mary Ann Foland, MD, President
For: The Alaska State Medical Association

Time to Revise the Approach to Determining Cardiopulmonary Resuscitation Status

Craig D. Blinderman, MD, MA
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In US hospitals, cardiopulmonary resuscitation (CPR) is the de facto default option—patients must "opt out" by requesting or consenting to a do-not-attempt-resuscitation order. Despite its worthy intent, requiring all patients or their surrogates to consent to a do-not-attempt-resuscitation order to avoid CPR has resulted in an ethically unjustifiable practice that exposes many patients to substantial harms.

Whenever there is a plausible risk of cardiac arrest, the standard approach is to ask patients or their surrogates about their preferences regarding CPR. However, the very act of asking can suggest to the patient and family that CPR may be beneficial, even when the clinician believes otherwise. Additionally, research in cognitive psychology has revealed that default options are often interpreted as recommendations or guidelines, or as the path of least resistance, and that such default options significantly affect decision making.[1] For these reasons, patients or their surrogates may be biased toward choosing full resuscitation status, even when CPR likely would bring little or no benefit and would risk considerable harm. Therefore, the standard approach of neutrally seeking consent to withhold CPR may inadvertently diminish patients' and families' comprehension of the clinical situation and lead to decisions that are grounded neither in patients' values[2] nor in their best interest.

Instead of assuming that CPR must always be offered, we suggest 3 distinct approaches based on the likelihood and degree of potential benefits and harms of resuscitation. In all 3 approaches, physicians must take the time to fully explain the patient's prognosis and likely disease trajectory, clarify any misconceptions, and elicit the patient's values and goals, which should form the basis for all CPR discussions. However, the options offered by the physician should change as the likely proportion of burdens to benefits increases.

Approach 1: Consider CPR as a Plausible Option

Physicians should discuss CPR as a plausible option when the relative benefits and harms of CPR are uncertain, as is often the case in patients whose chronic illness has not reached end stage. Fried et al[3] have shown that patient preferences for treatment are determined by their attitudes toward the burden of treatment and the likelihood of those possible outcomes. Thus, physicians should explore the patient's or surrogate's understanding of the disease, clarify any misconceptions, and discuss the likelihood of successful CPR (approximately 16% of hospitalized patients survive to discharge following CPR)[4] and possible harms of attempting CPR (eg, injury related to resuscitation efforts, prolonged stay in an intensive care unit, disability, anoxic brain injury, or nursing home placement). Physicians should seek a nuanced understanding of the patient's values and expect that patients in medically similar circumstances may choose differently. The discussion, the resulting resuscitation preferences and status, and the patient's values and goals should be recorded in the medical record.

Approach 2: Recommend Against CPR

Physicians should recommend against CPR when there is a low likelihood of benefit from CPR and a high likelihood of harm, such as when patients have advanced incurable cancer, advanced dementia, or end-stage liver disease.[4] Patients in this category who survive resuscitation are likely to spend their last hours or days in an intensive care unit or have an anoxic brain injury. The physician should approach such patients or their surrogates with a presumption against providing CPR but also remain attentive when discussing the patient's values and goals for unique personal, familial, religious, or cultural factors that might make an attempt at CPR unusually beneficial.

For most of these high-risk patients, physicians should recommend against CPR and explain that they do not want to expose the patient to a procedure that is unlikely to be beneficial and will most likely cause significant harm. Assent to this recommendation by a patient or surrogate would then allow the physician to write a do-not-attempt-resuscitation order. Physicians must be careful not to give

See also p 915.

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the impression that withholding CPR means giving up (ie, that other treatments will not be provided) or that the patient will be ignored or abandoned. On the contrary, physicians should explain that their intent is to protect the patient and ensure the best possible experience in the final phase of life.

Despite such a recommendation, some patients in this category or their surrogates may request that CPR be attempted for a variety of reasons, including religious or cultural beliefs. It is ethically acceptable for the physician to acquiesce to such a request as long as it is grounded in the patient's values and goals and there is a potential for a modicum of medical benefit.[5]

Approach 3: Do Not Offer CPR

Physicians should not offer CPR to the patient who will die imminently or has no chance of surviving CPR to the point of leaving the hospital. Once this determination is made, and absent extraordinary but reasonable patient values or goals that might make the harms of CPR in this situation worth risking, it is, in our opinion, not only ethical, but also imperative, that CPR not be offered. The physician's primary responsibility is to protect the patient from unnecessary harm. Indeed, CPR was not intended to be used in this clinical situation.[6]

Not offering CPR for imminently dying patients should be explicitly permitted by hospital policy. However, the decision not to offer CPR should be disclosed to the patient or surrogate. As in the previous approach, physicians should not give the impression that not attempting CPR means giving up or that the patient will be ignored or abandoned, but rather that the intent is to protect the patient from harm and maximize comfort.

If a patient or surrogate continues to insist that CPR be attempted, an ethics consultation should be requested if available. If the ethics consultants concur that the case falls within this clinical situation, and absent highly unusual patient values or goals, the consultants should gently and respectfully inform the patient or surrogate of their support for the decision to not attempt CPR and enter a note to this effect in the medical record. Support from a social worker, chaplain, or patient advocate should be made available to the patient and family as appropriate.

Conclusions

Whenever there is a reasonable chance that the benefits of CPR might outweigh its harms, CPR should be the default option. However, in imminently dying patients, a default status of full resuscitation is not justifiable. Not only is CPR in this situation likely to harm patients without compensatory benefit, the default framework likely influences patients and surrogates to request that full resuscitation is attempted even when the physician believes doing so may be inappropriate. The default option in this situation should be an order to not attempt CPR, perhaps coupled with consultation by a palliative care specialist. Similar reasoning may have motivated 15% of nursing homes in Wisconsin to develop policies that make withholding CPR the default option and to offer full-code status only on an opt-in basis.[7]

Physicians are responsible for recommending the medical means to honor their patients' values and for helping them to identify and achieve their health care goals. This responsibility becomes crucial in the setting of life-threatening illness, in which patients are especially vulnerable and may be exposed to potentially harmful life-sustaining interventions. While promotion of patient autonomy is a fundamental responsibility of physicians, protecting the patient from harm becomes increasingly important as the patient becomes more vulnerable. Sometimes, it should be preeminent.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Blinderman reported that he has served on speakers bureaus for Cephalon and has received travel accommodations and honorarium from the International Multidisciplinary Forum on Palliative Care for speaking at a conference in 2010 and from the Vietnam-Centers for Disease Control and Prevention-Harvard Medical School-AIDS Partnership for training and supporting Vietnamese clinicians in palliative care. Drs Krakauer and Solomon did not report any disclosures.

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