AN UNNATURAL DEATH AT AGE 102

Over the last half century there has been an evolution in end-of-life medical decision-making away from Hippocratic paternalism which vested full authority in the physician toward recognition that the last word always should be the patient’s - or if they’re unable to express themselves, by a trusted representative acting in their behalf. The seminal Karen Ann Quinlan decision by New Jersey’s Supreme Court in 1976 established that unwanted treatment can be eschewed even if thereby death might be hastened. Growing use of advance directives (“living wills”) and availability of hospice and palliative care alternatives to “curative” treatment have contributed to a changing dynamic of decision-making.

In this era when supervision by long-standing community physicians has become a rarity, especially in the hospital setting the challenge of representing the patient’s wishes or best interests has only been exacerbated. When surgery is considered for physically incapacitated or cognitively impaired patients of extreme old age, at the very least, this should require serious discussion between the operatives (surgeon and/or anesthesiologist) and the patient’s proxy. Nevertheless, despite decades of ethical and legal progress, vestiges of the old ways persist and, too often, communication falters. The following case report illustrates that the more things have changed the more they are the same.

CASE REPORT

A feisty but increasingly demented 102 year old woman, Mrs. M, (my sister-in-law’s mother) who lived in an assisted living facility in Sarasota, could ambulate with assistance until one day in December 2018 she fell and fractured her upper femur near the right hip. She was rushed to a local hospital’s emergency room where she received intravenous morphine.

Records sent to the hospital from the assisted living facility included a DNR order and an advance directive that was written in 1996 when the patient was 80 years old. In that standard form Mrs. M had requested that if there was “no medical probability of my recovery…life-prolonging procedures [should] be withheld or withdrawn…and that I be permitted to die naturally with only the administration of medication or any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.” Although that language did not precisely
correspond to the present situation, Mrs. M’s family presumed that no extraordinary measures would be given. At no time did anyone - admissions office, nurse or physician - ask whether an advance directive existed or what the patient herself might want under these circumstances if she were able to express herself.

An Emergency Room doctor explained to the daughter that given her condition, most likely Mrs. M never would walk again and surgery would not be advisable. She was admitted to an orthopedic ward, initially under hospice management for comfort care, but after the hospice staff reviewed her case the next day, they called the daughter explaining that “Mom is doing well” and did not meet criteria for in-hospital hospice. Although a community-based hospice was willing to accept her on the basis of age-related frailty, dementia, renal failure and the fracture, no bed was immediately available there.

An on-call orthopedic surgeon phoned and recommended a “very simple” procedure that would permit weight bearing and suggested that in a few weeks she might be able to walk again. Moreover, surgery would make her eligible for rehabilitation at a Skilled Nursing Facility. The family was concerned that since she couldn’t return to the assisted-living facility, but went to a nursing home without having had surgery, she wouldn’t be eligible for Medicare coverage. Faced with no other choice, they reluctantly gave permission.

Mrs. M was taken for surgery on 12/4/18 but immediately after induction of anesthesia she developed extreme bradycardia and hypotension. Atropine and repeated doses of epinephrine were administered and an external pacemaker attached. When the anesthetist felt that the heart rate was “satisfactory,” surgery (ORIF) was performed in slightly more than twenty minutes. However, immediately after the procedure ended she again developed severe bradycardia and received vasopressors for hypotension and bicarbonate for severe metabolic acidosis. After about a thirty minute stay in the recovery room and while being transferred to the intensive care unit on a different floor, she had a cardiac arrest and a “full code” was performed. It included at least one DC shock, she was placed on a respirator and resuscitation efforts were continued for a total of 78 minutes.
Immediately after surgery ended, and in his only direct meeting with the family, the orthopedist told them that the procedure had gone well - except for an “arrhythmia.” After Mrs. M died, the doctor never called to discuss what had happened or to express regret. What follows next is the testimony of Mrs. M’s daughter (personal communication):

I met the surgeon for the first time after the surgery when he indicated that everything went well, that she would be weight bearing and with rehab eventually could return to her assisted living facility. Nothing was said about cardiac complications during surgery. He told me to wait on her ward for her return. He later found me there and explained that she was having some rhythm issues so they would keep her intubated for a while longer and then she would be transferred to the ICU and followed by an internist. I was sent back to wait for another hour and eventually given a room number in the ICU and told to go there. When I entered the ICU she obviously had coded as there were many medical staff outside her room and they told me that she had expired.

In her report the pulmonologist stated that she was called STAT to the recovery room and proceeded with a full code protocol. She wrote that "when her daughter arrived at the bedside, she asked that we stop CPR and let her mother be peaceful." However, I was never called to the recovery room! Nor was I called to the ICU before or during her code.

In 1990 the United States Congress passed the Patient Self-Determination Act (PSDA) in response to public concerns over the medical profession’s lingering authoritarianism. The law provided that at the time of admission to a Federally-supported hospital, patients must be informed of their rights under state law to consent and refuse medical therapy and notation made whether or not an advance directive existed. Such organizations as the American Society of Anesthesiology, the American College of Surgeons and the Association of Operating Room Services have issued guidelines relevant to this issue and common to all was that an effort always should be made to seek and respect the patient’s preference.
The precise legal wording concerning end-of-life medical decision-making differs somewhat from state to state including how DNR orders that are applicable in the home or in community facilities get implemented upon hospital admission. Florida has revised its rules several times and a diagnosis of a “terminal” condition is no longer necessary - a physician is only required to obtain the patient’s informed consent or that of the patient’s designee. Treatment of a medical or surgical condition is considered appropriate or not only after truly informed consent has been obtained and documented. Certainly hospital admission is an opportune time to discuss prognosis and the goals or limits of conventional treatment.

A little-known exception to usual practice is that a do-not-resuscitate order (DNR) is automatically suspended in the operating room during and immediately after surgery. Some have argued that this violates the concept of patient autonomy and can not be ethically justified. In the current case not only did no one ask what the patient would have wanted but the family was never advised that an existing DNR order would be suspended during or immediately after surgery.

In 1975 and again in 1984 my partner and I published two articles in major journals (JAMA and JAGS) in which we described seventeen elderly nursing home patients whose hip fractures were treated non-surgically. Our second article was discussed in detail by medical journalist Lawrence Altman in the NY Times under the headline “Common-Sense Approach Urged For Hip Fractures in the Elderly” (July 17, 1984.) We reported that because surgery often fails to restore mobility in frail and often demented patients, that a decision to operate should not be automatic but reserved for cases when doctors are reasonably sure that the patient will walk again. Good medical and nursing care are more effective than surgery in providing comfort and preventing complications and is less likely to lead to further mental deterioration or even death. But, evidently, some orthopedists and others still haven’t learned the lesson that common-sense always should prevail and that informed communication should always define the doctor-patient relationship.

In retrospect bad judgement abounded in this case, communications were abysmal and Mrs. M’s death at age 102 certainly was “undignified.” The hospital failed what should have been its primary goal which was to do what was in the best interest of a patient. For a patient who obviously is nearing the end of life
this means to provide comfort and to do no harm - all the more with a prior DNR order and advance directive available.

In our increasingly depersonalized health care system it’s necessary to remember that patients are persons, not merely dysfunctional body parts. Although this applies at all ages, for those of extremely advanced age, mental as well as physical function, quality of life and the patient’s previously stated wishes and values always should be considered. Obviously more work needs to be done.

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