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Risk Management Pitfalls For Dyspneic Patients At The End Of Life

1. **"I don't want to do anything aggressive to her because she's DNR."** Remember that DNR does not mean "do not treat." This order only applies to care that is delivered when the patient has experienced a full cardiopulmonary arrest. Many patients who elect to be DNR would like other treatments (such as IV fluids and even intubation), particularly in the setting of a reversible process.

2. **"The person at the bedside seems to know the patient well, so I'll just let him make all of the decisions."** Physicians should make reasonable efforts to determine who the patient's legal and appropriate decision-makers are. In some states, healthcare providers are protected from civil and legal liability if they are determined to have navigated this process in good faith.

3. **"The family says they want everything done. It seems like a strange decision given the patient's prognosis, but it's not for me to explore this further. I will assume that means they want her to be intubated and that they want a central line placed so that vasopressor therapy can be initiated."** Patients and families often say they want "everything" without fully understanding what this means or the implications of certain treatment decisions (such as intubation). It is better to ask them what they are hoping for, in light of the patient's condition, and then make treatment recommendations that allow their goals to be met.

4. **"I can't give morphine to a patient in respiratory distress. I don't want to be accused of euthanizing anyone!"** Opioids are the first-line treatment for dyspnea at the EOL. They are safe and effective when used in appropriate doses to target symptoms. Withholding this widely accepted palliative intervention is inappropriate, particularly in patients endorsing comfort as their primary goal.

5. **"How was I supposed to know the patient had a POLST designating his care to be focused on 'comfort measures only?'** I assume if he's coming to the ED, he must want something more." Healthcare providers should be diligent in searching for previously completed advance directives, particularly in patients transitioning from the nursing home environment, as advance directives are now widely employed in this setting. Many patients develop significant symptoms at the EOL, and not all nursing homes and/or families are prepared to manage the complex needs of such patients (particularly in the absence of hospice services).

6. **"The patient is dying and the family says she only wants comfort-focused care, but I have religious objections to just allowing a patient to die. I'm going to intubate her and let the team upstairs sort this out."** One of the most important ethical principles that should guide physician behavior is that of patient autonomy. Patients have a legal and ethical right to determine what happens to their bodies. Particularly in the setting of a terminal illness, it is reasonable and normal that patients and families may decide to forgo life-sustaining treatments and focus on maximizing quality of life. If the physician caring for the patient has ethical objections to such decisions, he or she is obligated to find another physician who can honor the wishes and needs of the patient.

7. **"This patient is here all the time for respiratory failure secondary to her COPD, and yet she keeps smoking. This feels futile and like a total waste of resources. I refuse to intubate her this time."** Patients have a right, within reason, to determine what happens to their bodies. Particularly in the setting of an organ-failure diagnosis like COPD, short-term periods of critical care may result in significant improvement in the patient's condition and allow the patient to recover with a reasonable quality of life. In the context of medical ethics, justice is an important ethical principle that pertains to the equitable distribution of resources. Decisions regarding justice should largely be made at the policy level, while individual physician-patient encounters should largely be guided by the principles of autonomy, beneficence, and nonmaleficence.

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8. **"I just had a really informative conversation with the patient and have a full understanding of her treatment goals, which include focusing on her comfort and not prolonging her dying process. But I am way too busy to write this stuff down in the chart, so I'll just communicate my discussion with the inpatient team."** All important discussions about EOL decisionmaking should be documented appropriately in the patient's chart. Individual institutions have different policies about how DNR and DNI documentation should occur, but a witness to such discussions is often required. Many patients who are dying eventually lose their ability to make decisions, which makes any direct conversations about treatment preferences of critical value to future care.

9. **"The patient clearly said he didn't want to be intubated, but he's too sick to communicate now, and his daughter is telling me to do everything. I don't want to get sued."** The entire role of surrogate decision-makers is generally to promote patient autonomy and specifically to make decisions that the patient cannot make for himself or herself. If the patient has already clearly made a decision and it has been witnessed and well documented, surrogate decision-makers do not have the legal or ethical right to override that decision.

10. **"The patient is in respiratory distress but is DNR/DNI. I can't just do nothing, so I'll put him on BiPAP® until he passes away."** NIPPV can be an important intervention for patients with acute dyspnea, particularly in those with underlying diagnoses such as COPD and CHF. For patients who are DNR/DNI, NIPPV might facilitate recovery from an acute decompensation, even for patients with dyspnea approaching the EOL. Nonetheless, some patients are not interested in artificially prolonging the dying process and/or find the NIPPV delivery system burdensome, rendering this an inappropriate intervention. In others, after a timelimited trial of NIPPV, it becomes apparent that the patient is on an irreversible dying trajectory. For such patients, NIPPV is likely burdensome, causing feelings of suffocation and discomfort at the EOL.

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