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Failure-to-Pursue Rescue: Truly a Failure?

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To the Editor

We read Scarborough and colleagues' manuscript and the ensuing discussion at the ASA Annual Meeting with great interest.¹ We found the methods to be extremely rigorous and the conclusions of the article thought-provoking. However, there are several points raised that seemed worthy of clarification.

Dr. Estes comments that the joint commission requires hospitals to create and include an advance directive on the charts of all patients at the time of admission. This is incorrect. The Patient Self Determination Act of 1990 (PSDA), to which he refers, requires only that hospitals receiving federal funding (Medicare or Medicaid) inform patients about their ability to play a role in healthcare decision making.² Specifically, healthcare facilities are required to give patients a written summary of their healthcare decision-making rights, including the right to accept or refuse proposed treatments and the right to prepare an advance directive. The PSDA requires hospitals to ask patients whether they have an existing advance directive and record the answer to this question in the medical record.³ This is typically done by the admitting nurse and documented on the hospital intake form. The law does not require anything beyond this; thus, there is no requirement to ask patients to create an advance directive or even to discuss advance care planning with patients. If patients have an advance directive, it is the patient's responsibility to provide this document to the hospital. Likewise, if patients do not have an advance directive but would like to prepare one, hospitals can provide services to assist with this, but they are not required to ensure that there is an advance directive on file. Under the best circumstances, the requirements of the PSDA can stimulate discussion between patients and caregivers about preferences for end-of-life care. However, patient responses about advance directives are typically logged in the chart along with a substantial number of other items asked at admission, and these responses may not actively reflect patients' treatment preferences.

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Conflicts of Interest

Both Terrah Paul Olson and Margaret L. Schwarze have no conflicts of interest to declare, including any financial, consultant, institutional, or other relationships that might lead to bias or conflict of interest.

A second discussant invoked the American College of Surgeons (ACS) position statement on “do not resuscitate (DNR)” orders in the operating room. Dr. Zenilman claimed, inaccurately, that the College’s position is to suspend advance directives peri-operatively. In fact, the ACS Statement on Advance Directives by Patients: “Do Not Resuscitate” in the Operating Room [ST-19] recommends a “policy of ‘required reconsideration’ of previous advance directives” rather than blanket suspension of advance directives during and after operations.⁴ While it may be perfectly appropriate to set aside an advance directive during surgery, a policy that routinely sets aside stated preferences without any discussion with the patient violates his or her ability to make autonomous decisions regarding health care. Instead, the policy asks surgeons to preoperatively discuss the risks and interventions that may accompany surgery and elicit the patient’s goals and preferences for this setting. This discussion may lead to suspension of advance directives for a defined period, but it is also possible that continuing a DNR order or limiting certain life-sustaining therapies in the operating room may be more consistent with the patient’s desires.

We would like to congratulate Scarborough and colleagues for their focus on the outcomes of surgery in a frail population by using a robust database and a powerful statistical tool in a thoughtful manner. However, the framing of their discussion – as a “failure” to pursue rescue on the part of the surgeon – is unfortunate. Perhaps it might be better conceived as a “success” in abiding by patient preferences. Note, the patients in the “DNR” group were by and large elderly with *many* serious comorbidities who had already shown interest in limiting aggressive and potentially burdensome medical treatment as evidenced by their DNR advance directive.

Additionally, patients in both groups had high rates of non-independent functional status, malnutrition and cerebrovascular disease. Furthermore, the greatest differences in mortality between the two groups occurred in the setting of complications that frequently require burdensome interventions (for example: pneumonia and ventilatory support, renal failure and hemodialysis, organ space infections and drainage or reoperation – see Figure 1 in Scarborough et al.¹). Finally, even in the non-DNR group, the rate of postoperative mortality in the setting of a major complication was still quite high at 41%. Although this is indeed less than the mortality of almost 57% seen in the DNR group, there is an absolute risk reduction with aggressive treatment of only 15%.

Other researchers have shown that patients often do not want intensive interventions near the end of life, particularly if the outcomes are uncertain or potentially burdensome.^{5,6} In light of this, perhaps we should think about the findings of this study not as a failure to pursue rescue in a very sick population, but rather as a success in eliciting and honoring patient preferences about goals of treatment. By labeling the higher mortality outcome in the DNR group as “failure,” we fail to acknowledge that surgeons and surgery are valuable to patients and their families even if the eventual outcome of treatment is death. As the authors point out, these patients present in severe pain and may be willing to undergo an emergency operation as a form of “comfort care.” However, as the clinical course unfolds and complications ensue, less aggressive treatment may be more in line with patient goals once again.

If there is any failure, perhaps it is in the non-DNR group. These patients were as sick as the DNR patients and yet they underwent reoperation and potentially other burdensome interventions with a resulting 41% mortality rate. For this group it is worth pondering whether there was a failure to elicit patient preferences or have a meaningful discussion about the realistic outcomes of surgery. However, as Scarborough and colleagues rightly point out, this level of detail is not captured in the ACS NSQIP data and needs to be explored further.

Surgeons have a duty to have frank discussions with patients preoperatively that provide accurate information about what they can reasonably expect during and after an operation. This includes a conversation about the patient's goals and fears specifically about burdensome treatments and potentially unacceptable health states. The study by Scarborough and colleagues provides valuable information to help inform these discussions with patients and their families. The high rate of major postoperative complications and accompanying mortality in this frail elderly cohort forcefully reminds us about the limitations of surgical care. We should not consider it a failure if patients decide that the quality of life offered by another operation or intervention is unacceptable. The real failure occurs when we are unable to understand and act on our patients' preferences.

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