
An Emergency Physician's Perspective on Death with Dignity

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Paramedics respond to the cardiac arrest of an elderly man in his home. As they start CPR, the son produces a valid living will with "no resuscitation" instructions. While they are discussing this with me at the Medicom base station, another son runs in, tears up the living will, punches his brother and demands CPR, which was then restarted.

A young hanging victim with a hopeless brain injury has a cardiac arrest. I spend more time after responding to the ICU, helping the mother come to grips with stopping futile CPR than actually doing "medical care."

A comatose man with an horrendous brain injury from a gunshot wound goes to ICU on a ventilator after I had a long discussion with the mother about organ donation. He ultimately leaves rehab walking and talking.

A 95-year-old man with terminal metastatic cancer comes to the ER in cardiac arrest. The family demands that "everything be done." He spends his final days in ICU comatose with multiple tubes, machines, etc.

A chronically ill woman with a valid living will has a respiratory and cardiac arrest at home when her guardian is out shopping. After CPR, she is on the ventilator in the ER when the family arrives with all the documents and begs me to stop treatment and let her die at home. We discontinue everything, they take her home and after dying at home, the body is returned three hours later for pronouncement. Incidentally, I had to ask the police officer to reword his report that said "patient came to ER with trouble breathing and Dr Holschuh sent her home to die."

An elderly woman with smoking-related terminal chronic obstructive pulmonary disease (COPD) with a valid living will stating "No ventilator care or intubation," comes by ambulance in pulmonary failure. As she is slipping into unconsciousness, in spite of initial treatment, from CO₂ retention, her eyes open and she gasps "Please save me." Since she verbally countered her advanced directive she was immediately intubated and survived that episode.

A 50-year-old man walked alone into the emergency department up to the nursing desk. He reached out to get attention and collapsed in cardiac arrest. The crash cart was brought to the spot, he was defibrillated immediately and about one week later came by the emergency department to thank the staff for "his life." We had no idea who he was or whether he had an advance directive that first day.

All of these are real cases that happened to me within the last few years in Hilo. All of them demonstrate how complex end-of-life decision making can become and the importance of good communication in the process. Whatever one believes about God or a Creator, man may have been given wisdom and skill by the Creator, but the Creator didn't produce the machines or technology. Our scientific advances have far outstripped our ethical understanding, good intentions, and common sense. We have a legal system that at times paralyzes caregivers who attempt to make sound decisions. And, we are now faced with emerging health delivery models that

some patients fear may someday stop lifesaving treatments for chronically ill people to save money.

At the June 1996 Annual AMA House of Delegates meeting in Chicago, a nationally publicized debate took place regarding resolutions that asked the AMA to alter its position against physician-assisted suicide to at least a neutral position. Recent U.S. Circuit Court of Appeals decisions on the east coast and the 9th Circuit Court (which includes Hawaii) have essentially removed prohibitions on physician-assisted suicide. I got the feeling that many of the physicians who spoke at the reference committee and on the floor of the AMA House of Delegates against physician-assisted suicide might in private discussion feel differently if they felt they had no voice in terminating their own end of life care.

The U.S. Supreme Court is taking up the circuit court decisions, and the AMA held to its position against physician-assisted suicide but some very interesting discussions occurred at the AMA which lead me to think we must continue to participate in all these discussions and debates, keeping the patient's best interests as our focus.

The activist group "Not Dead Yet" which represents many disabled individuals, lobbied against physician-assisted suicide at the AMA meeting. They have been very outspoken nationally and have called Dr Jack Kevorkian a "serial killer." I spoke with some of the protest group members including a very articulate attorney who is afflicted with some neuromuscular disorder and is wheelchair bound. She emphasized the very real concern that many of them have, that a vote to change the AMA position might eventually lead to overzealous attempts by managed care organizations to end the lives of severely challenged people. Many of their members are on home ventilators and fear attempts to discontinue their use. Some points of debate and discussion which I feel need to be continued:

(1) Physicians must be sure the discussion on dying is brought up early on with patients and families. Families and patients must be counseled that withholding resuscitative efforts and extreme technological support is not equivalent to lack of caring. Quite the opposite; often not treating a specific terminal condition and addressing the dying process may be the ultimate act of caring.

(2) Physicians must be able to relieve pain and suffering, even if it hastens death; without fear of legal challenges.

(3) As Dr Stephen Wallach, Honolulu cardiologist, has often said, we don't want to damage the existing living will laws, but we can make it work better without legislation by good communication with patients and families. When my parents did their first living wills, my mom wouldn't have allowed the Heimlich maneuver until I explained specific details of resuscitation. For instance, if a patient has a living will addressing a terminal condition and has an electric shock or near drowning, do you not treat these reversible conditions? It gets back to common sense and good communication.

(4) Physicians must be more proactive with advanced directives. I see many chronically ill patients in the emergency department who

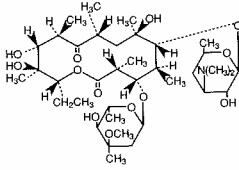
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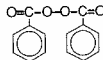
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Erythromycin (C₂₇H₄₅N₂O₁₃) is produced by a strain of *Streptomyces erythraeus* and belongs to the macrolide group of antibiotics. Erythromycin has a molecular weight of 733.94 and is represented by the following structural formula:



Benzoyl peroxide (C₁₄H₁₀O₄) is an antibacterial and keratolytic agent. The structural formula is:



Clinical Pharmacology: Erythromycin is a bacteriostatic macrolide antibiotic, but may be bactericidal in high concentrations. Although the mechanism by which erythromycin acts in reducing inflammatory lesions of acne vulgaris is unknown, it is presumably due to its antibiotic action. Antagonism has been demonstrated between clindamycin and erythromycin.

Benzoyl peroxide is an antibacterial agent which has been shown to be effective against *Propionibacterium acnes*, an anaerobe found in sebaceous follicles and comedones. The antibacterial action of benzoyl peroxide is believed to be due to the release of active oxygen. Benzoyl peroxide has a keratolytic and desquamative effect which may also contribute to its efficacy.

Benzoyl peroxide has been shown to be absorbed by the skin where it is converted to benzoic acid.

Indications and Usage: Benzamycin Topical Gel is indicated for the topical control of acne vulgaris.

Contraindications: Benzamycin Topical Gel is contraindicated in those patients with a history of hypersensitivity to erythromycin, benzoyl peroxide or any of the other listed ingredients.

Precautions: General—For external use only. Not for ophthalmic use. Avoid contact with eyes and mucous membranes. Concomitant topical acne therapy should be used with caution because a possible cumulative irritancy effect may occur, especially with peeling, desquamating or abrasive agents. If severe irritation develops, discontinue use and institute appropriate therapy.

The use of antibiotic agents may be associated with the overgrowth of antibiotic-resistant organisms. If this occurs, administration of this drug should be discontinued and appropriate measures taken.

Information for Patients—Patients using Benzamycin Topical Gel should receive the following information and instructions:

1. Benzamycin Topical Gel is for external use only. Avoid contact with the eyes and mucous membranes.
2. Patient should not use any other topical acne preparation unless otherwise directed by physician.
3. Benzamycin Topical Gel may bleach hair or colored fabric.
4. If excessive irritation or dryness should occur, patient should discontinue medication and consult physician.
5. Discard product after 3 months and obtain fresh material.

Carcinogenesis, Mutagenesis and Impairment of Fertility: Long-term studies in animals have not been performed to evaluate carcinogenic potential or the effect on fertility.

Pregnancy Category C: Animal reproduction studies have not been conducted with Benzamycin[®] Topical Gel. It is also not known whether Benzamycin Topical Gel can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Benzamycin Topical Gel should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Benzamycin Topical Gel is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 have not been established.

Adverse Reactions: Adverse reactions which may occur include dryness, erythema and pruritus. Of a total of 153 patients treated with Benzamycin Topical Gel during clinical trials, 4 patients experienced adverse reactions, of whom three experienced dryness and one an urticarial reaction which responded well to symptomatic treatment.

Dosage and Administration: Benzamycin Topical Gel should be applied twice daily, morning and evening, or as directed by physician, to affected areas after the skin is thoroughly washed, rinsed with warm water and gently patted dry.

How Supplied and Compounding Directions:

Size (Net Weight)	NDC 0066-	Benzoyl Peroxide Gel	Active Erythromycin Powder (In Plastic Vial)	Ethyl Alcohol (70%) To Be Added
23.3 grams (as dispensed)	0510-23	20 grams	0.8 grams	3 mL
46.6 grams (as dispensed)	0510-46	40 grams	1.6 grams	6 mL

Prior to dispensing, tap vial until all powder flows freely. Add the indicated amount of ethyl alcohol (70%) to vial (to the mark) and immediately shake to completely dissolve erythromycin. Add this solution to gel and stir until homogeneous in appearance (1 to 1½ minutes). Benzamycin Topical Gel should then be stored under refrigeration. Do not freeze. Place a 3-month expiration date on the label.

NOTE: Prior to reconstitution, store at room temperature. After reconstitution, store under refrigeration. Do not freeze. Keep tightly closed. Keep out of the reach of children.

Caution: Federal (U.S.A.) law prohibits dispensing without prescription.

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Reference:

1. Mills OH, Berger RS. A double-blind evaluation of tretinoin alone and in combination with erythromycin/benzoyl peroxide in acne vulgaris. *Cutis*. 1992;49(6A):12-15.
2. Leyden JJ, Shalita AR. Rational therapy for acne vulgaris: An update on topical treatment. *J Am Acad Dermatol*. 1986;15:907-915.
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have never had living will discussions brought up by their doctors. I recently had a discussion about advanced directives with the children of a patient with end stage heart disease, who thought the discussion of a living will was the equivalent of contemplating euthanasia. We as a medical association must help with far reaching public education.

(5) We must bring the discussion of comfort care, quality of life, and similar issues back into our patient care activities. It is easier to activate our high tech medical system than to evaluate the benefits of doing so. A recent *New England Journal of Medicine* article on the results of resuscitation on "ER," "Chicago Hope" and "Rescue 911" showed that the public is given an "unrealistic impression of CPR and its chances for success."¹ I've actually had people in the Hilo ER assume that arrival by ambulance at the hospital after a cardiac arrest equals survival.

(6) Physicians must support their patient's valid advanced directives. I'm very distressed at seeing family members sometimes successfully coerce a treating physician into not following mom or dad's advanced directive. In my opinion, this should include decisions on organ donation. There must be sanctity in these decisions. We would want nothing less for ourselves.

(7) Because so many people are addressing physician-assisted suicide and voluntary euthanasia, I think organized medicine must at least be involved in these discussions.

Finally, a George Washington University gerontologist says she can get intensive care for her patients easier than she can get them eyeglasses.²

The late Dr David Eckstein, former chair of the medical society of New Jersey Committee on Biomedical Ethics stated "Do the best for the patient—not necessarily the most."³

Dr William Knaus quoted in a People Magazine article "Last Passage" said: "Death is universal; its never too early to start talking about it. We need to recognize that dying is one of the more important things we will do in life. It will be the last memory we leave to those we love. And if we want to do it better, than we're going to have to talk about it."²

References

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