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Beyond the Frontiers of Medicine

"The description of new diseases," to quote a *Lancet* editorial, is "a favorite medical pastime, often commanding the unbridled enthusiasm of the adventurer who seeks uncharted territories where no rules have been fixed" (16 January 1993). The chronicles of those intrepid adventurers appear regularly in the major journals, the correspondence pages of which seem a privileged forum for the illumination of new clinical conundrums.

Take, for example, a case of "margarita photodermatitis" reported in *NEJM* (25 March 1993). The patient presented with "burning, severe swelling, and blistering of his left hand." The diagnosis of photodermatitis was made following revelations that two days previously the patient had squeezed some five dozen limes in the course of making a "large quantity" of margaritas, whereupon he had spent the rest of the afternoon sunbathing. The condition is usually described as an occupational hazard of citrus workers and celery harvesters.

Among the more arcane clinical entities discovered this year (appearing again in *NEJM*, interestingly), many seem to be more or less sex-linked—thus "stretcher's scrotum" and "beauty parlor stroke syndrome." The former, first recognized in a "forty-year-old recreational athlete," involved "acute scrotal swelling and pain" subsequent to the patient's performing stretching exercises recommended as rehabilitation for a lower back injury. Upon having the patient reenact his stretching routine, the treating physician discerned "compression of the testes when one knee was brought to the chest and restrictive gym shorts were worn" (18 March 1993). Those prescribing flexibility exercises should remind male patients to wear loose, stretchable clothing . . .

Women more often risk "beauty parlor stroke syndrome" according to a report in *Medical Tribune* (13 May 1993). The neck rotation and hyperextension involved in those oh so lux-

IN BRIEF

urious professional shampoos can, it turns out, reduce vertebral artery flow and cause other injuries that may lead ultimately to stroke. For older clients particularly, beauticians are urged to adopt a safer flexed posture during washing.

"Voracious shredder syndrome," which is characterized by temporary neck pain brought on by catching one's tie in the office document shredder (*NEJM*, 4 February 1993), would seem to qualify as a largely androgynous hazard. Effective preventive measures are use of "a proper tie clasp" or switching from standard to bow ties. Women who don other, similarly hazardous neckware would be advised to follow analogous precautions, we assume. Further instruction in the safe use of office equipment might also be encouraged, of course.

As the *Lancet* editorialist noted (albeit in a more serious vein), "the roller coaster of disease creation and disappearance will roll on . . ."—**BJC**

Jumping to the Wrong Conclusion: Don't assume that hospice programs are only beginning to be established in the Netherlands just because the Dutch tolerate euthanasia. That's too simple an account, says an article in the *American Journal of Hospice & Palliative Care*, which cites poor historical experience with terminal care programs, absence of a strong cultural tradition of voluntarism, and lack of specific training in palliative care for clinicians, among other factors.



Washington State's No CPR Program

In 1992 the legislature of Washington State made important revisions to Washington's Natural Death Act. Among the revisions was a directive instructing the Department of Health to "adopt guidelines and protocols for how emergency medical personnel shall respond when summoned to the site of an injury or illness for the treatment of a person who has signed a written directive or durable power of attorney requesting that he or she not receive futile emergency medical treatment."

In response, a "DNR Workgroup" was formed and has drafted a near-final version of EMS (emergency medical service) guidelines for No CPR (cardiopulmonary resuscitation). The guidelines enable EMS personnel to withhold CPR from residents of Washington State, provided they have:

- completed an advance directive, such as a living will or durable power of attorney for health care;
- obtained from their attending physician (defined as the physician with primary responsibility for the patient's care) a statement certifying the applicability of the advance directive (in Washington State, this requires that the patient be either terminally ill or in a permanently unconscious condition);
- obtained through their attending physician an EMS-No CPR bracelet and form, both of which have been signed by the patient's physician or, in the case of a patient with a permanent unconscious condition, signed by both the attending and a consulting physician.

As a result of these changes, a terminally ill AIDS patient, for example, or an end-stage cancer patient, who wears the EMS-No CPR bracelet or carries the original EMS-No CPR form will not receive basic CPR, intubation, cardiac monitoring and defibrillation, administration of resuscitation medications, or any positive pressure ventilation. Other forms of support will, however, be carried out, including opening and clearing the

airway, providing oxygen per nasal cannula, making the patient comfortable, offering emotional support to the patient and family, controlling bleeding, providing pain medications, and possibly contacting the patient's physician or on-line medical control if problems arise.

The idea of a patient bracelet to alert medics of a terminally ill patient's status was originally developed by the EMS Division of the State of Virginia, and was subsequently adopted by Connecticut, Colorado, New Hampshire, New York, and Virginia. The bracelet, which is worn on either the patient's wrist or ankle, or attached to a necklace, can be honored in lieu of a signed EMS-No CPR form. Conversely, the signed form must be honored even when there is no accompanying bracelet.

The single most important effect of these changes will be to enable emergency personnel to honor the wishes of terminally ill or permanently unconscious persons who want CPR withheld. Another extremely significant result will be that these patients or their families will be able to phone 911 and receive emotional support, comfort measures, and therapies to alleviate pain. As the draft guidelines poignantly state, "No CPR does not mean No Treatment or No Caring. . . . [Caring] is an important responsibility and service you provide to terminally ill patients and their families at an important moment in their life."

Although these changes mark needed progress toward more ethical use of resuscitation in the field, they are unfortunately limited. According to Karen Cooper, Executive Director of Washington State's Citizens for Patient Self-Determination, the new guidelines do not go far enough because doctors, under current law, would be reluctant to supply an EMS-No CPR bracelet or form to patients who are not terminally ill or permanently unconscious. In Washington State, a DNAR (Do Not Attempt Resuscitation) order, which may be written regardless of whether a patient is terminally ill or permanently unconscious, is not "portable" and cannot be used outside the hospital setting.

In addition, the guidelines do not attempt to address the thorny problem of how physicians can prevent the use of nonbeneficial or "futile" resuscitation in the field. The ethical basis for ceasing futile resuscitation should not be that a patient or surrogate has refused it, but rather that the experience of health professionals has shown that the intervention is extremely unlikely to offer even a minimal benefit to the patient.

Nevertheless, the new guidelines should encourage these future steps to enhance ethical decisionmaking in the out-of-hospital emergency setting.—**Nancy S. Jecker**, University of Washington, School of Medicine, Seattle.

From Russia with Love: The International Institute of Biological Medicine in Moscow has contracted to provide enough aborted fetal tissue to perform forty pancreatic transplants for diabetic patients at a Santa Barbara, California, clinic. Although President Clinton rescinded the Bush administration's 1988 moratorium on fetal tissue transplantation, tissue is not yet widely available in the U.S.



Where Docs Draw the Line

To what extent do physicians feel obligated to honor patients' requests, particularly regarding treatment at the end of life? According to a survey in the *Archives of Internal Medicine* (22 March 1993), that depends very largely on what the request happens to be. Terri R. Fried and colleagues presented 392 physicians in Rhode Island with a hypothetical patient in the person of an eighty-year-old man,

well known to the respondent, with terminal metastatic lung cancer, competent, and not depressed. They asked whether the physician would comply with any of a range of five patient requests: (1) withholding ventilator support, (2) adequate pain management even if it compromised respiratory function, (3) turning off a ventilator, (4) prescribing a lethal dose of sleeping pills, and (5) giving a lethal injection.

Of the 256 respondents, 97.7 percent said they would comply with the request to withhold ventilator support, 86.3 percent would provide adequate pain management, 59.4 percent would turn off the ventilator at the patient's request, 8.6 percent would write a prescription for a deadly number of sleeping pills, and 1.2 percent agreed to the lethal injection. What seemed to inhibit some 25 percent of the physicians who were unwilling to turn off the ventilator was their belief that the courts would not uphold such an action—a belief that runs contrary to a number of state supreme court judgments. The authors suggest that "education about legal precedents might diminish the insecurity felt by these physicians."

In another survey—this one polling 1,381 geriatricians across the U.S.—the question was confined to physicians' attitudes toward assisting suicide of the nonterminally ill, using the case of Janet Adkins and Jack Kevorkian as the paradigm (*Journal of the American Geriatrics Society*, September 1992). Of the 727 who responded, 14 percent were of the opinion that Dr. Kevorkian's assistance was morally justifiable—a greater number than the 9 percent in the *Archives* survey who were willing to prescribe a suicidal number of sleeping pills for a patient dying of cancer.

In yet another survey, approximately 800 readers of *Hippocrates* (March 1993) answered eight questions, one of which asked whether they would "actively help to end the life of a competent, terminally ill patient with a dismal prognosis." A hefty 28 percent said they would, if the patient asked them to and the family agreed. This figure plummets