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Withdrawal of Care in the ED

An elderly nursing home resident was brought to the ED by ambulance at 11 PM because of a sudden deterioration in her level of consciousness. An incomplete transfer form accompanied her, and the nursing home staff on duty was unfamiliar with her history. In the ED, her breathing and O_2 saturation deteriorated and she was quickly intubated. Afterwards, CT revealed a subarachnoid hemorrhage (SAH) with no herniation. Neurosurgery accepted her for the last ICU bed in the hospital—a bed that had just been assigned to another ED patient, who would now remain in the ED. Before the patient was transported to the ICU, her adult children arrived and informed the staff that their mother had been severely demented for over a year, and that they had cosigned a valid advance directive specifying DNR/DNI. They requested that their mother be extubated and that the consequences of the SAH be allowed to occur without further intervention.

Three recent cases involving requests for withdrawal of care in the ED have convinced me that this issue will almost certainly occur with increasing frequency as the population continues to age. Withdrawal of care is a lengthy, time-consuming process—as it should be—and one that should ideally occur with family support, in a quiet place and in a dignified manner. Until recently, I've felt strongly that the ED is not the right place for it.

I've stopped wondering why people call 911 when the last thing they want is someone to resuscitate a relative who is dying of an incurable and sometimes painful illness. In such instances, the call is not intended to prevent or delay the inevitable—only to have it take place elsewhere. However, when a clear and valid advance directive is not available to responding EMTs or paramedics, they may not be able to withhold care. (In retirement communities, residents are often advised to attach a valid DNR/DNI document to the refrigerator as a reliable means of ensuring its availability when needed.) Although I can sympathize with families who call 911 for dying relatives, I think there should be a special place in medical-legal hell for nursing homes that neglect to send valid DNR/DNI documents to EDs with patients—especially when the ambulance should not have been called in the first place.

To be sure, there are several problems with conducting withdrawals of care in the ED. When you hear about an incorrectly identified ED patient receiving treatment intended for another, or a wrong medication dose being administered, or a second or third sibling arriving and arguing over possible end-of-life treatment for an elderly parent, it becomes obvious that the ED is too dangerous a place to routinely conduct withdrawals of care. Although using a needed ED space for 3 hours or more to discontinue an unindicated intubation is a high price to pay to avoid an admission, delaying resuscitation while trying to confirm DNR status could turn out to be a catastrophic mistake. But what if there is inadequate inpatient space—particularly ICU beds—to admit both a dying patient from the ED and another patient whose life may depend on access to that care?

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In many hospitals, the only place to reliably find an attending physician at night is the ED. So, I can understand why the ED may have to be utilized, and I no longer think that ED space should *never* be used for withdrawal of care. At the same time, however, I worry that every time the ED tries to help the situation, it almost guarantees that such requests will become more frequent—and eventually, the expectation or rule. □