RESUSCITATION ATTEMPTS IN ASYSTOLIC PATIENTS: THE LEGAL TAIL WAGGING THE DOG?

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Abstract—In today’s litigious society, legal worries can cause Emergency practitioners to alter their delivery of clinical care. One clinical scenario in which this particularly true is in resuscitation of the so called “medically futile” patient. Patients who arrive to the Emergency Department in prolonged asystole have a uniformly dismal prognosis at best. Yet, many Emergency Physicians often continue resuscitative efforts for fear of being sued. These fears are largely unjustified. This article attempts to analyze the factors and elements involved in support of the assertion that the risk of a lawsuit is negligible at best. © 2006 Elsevier Inc.

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INTRODUCTION

Emergency physicians often continue unsuccessful EMS resuscitative efforts on the “medically futile” patient, even after the patient arrives in the Emergency Department. Some have suggested that a significant factor in this behavior has been a “fear of litigation” on the part of the emergency physician (1). In the context of the “medically futile” patient, this fear seems to be unfounded for several reasons.

In addition to realistic economic considerations, plaintiff attorneys would have a difficult time establishing a claim of medical negligence. Difficulties in proving breach of care, causation and damages would make this type of suit extremely unappealing to most plaintiff attorneys.

Part I of this paper identifies the subset of patients who comprise the “medically futile.” It then proceeds to review the medical literature that demonstrates the poor prognosis of this subset of patients. Part II offers a legal perspective as to why a claim of medical negligence would be so difficult to prove. Part III concludes by suggesting that emergency physicians should alter their current practice and suggests some ways that this can be accomplished.

MEDICAL FUTILITY

Since the advent of Advanced Cardiac Life Support (ACLS) nearly 30 years ago, there has always been a subset of patients who have suffered dismal outcomes, the so-called “medically futile” patient. Although there is no accepted medical definition of “medical futility,” most emergency physicians would agree that the overwhelming majority of patients who arrive in the Emergency Department (ED) in asystole after prolonged prehospital resuscitative efforts are unlikely to survive (2–8).

As early as 1985, Smith and Bodai proposed a set of resuscitation termination guidelines based on a number of poor prognostic factors described in earlier studies (9).
These guidelines suggested that patients who have received pre-hospital advanced cardiac life support (ACLS) for more than 45 min without establishing a native rhythm are not salvageable by current standards and therefore termination of efforts is warranted (9). Numerous other studies conducted since this review have confirmed the nearly uniformly dismal outcomes for patients with a pre-hospital initial rhythm of asystole (5,8,10).

There are certain clinical circumstances in which patients have been reported to recover from prolonged bouts of asystole (11). In fact, the latest American Heart Association Guidelines acknowledges as much in its latest recommendations for the treatment of asystole (12). Part of the asystole algorithm now includes a careful search for any atypical clinical features (i.e., age, toxin or drug overdose, or profound hypothermia) for which there have been scattered reports of clinical recovery (12–14). If these unique clinical circumstances are absent, however, the algorithm recommends ceasing any further resuscitative efforts.

Despite all of the medical evidence to the contrary, many emergency physicians continue the practice of a “second code” once the patient arrives in the ED. Although there may be other reasons for this practice, fear of lawsuit is a central reason for physician behavior (1). The next section analyzes this behavior from a legal perspective and asserts that this fear may be unwarranted.

LEGAL ISSUES

Legal Background

Malpractice suits are a matter of state common law. The cause of action is generally a claim of medical negligence. In any negligence claim, the injured party has the burden to establish all of the elements that define a negligence action.

First, the plaintiff must prove that the defendant had a duty to the plaintiff. Secondly, it must be established that the defendant breached that duty. Thirdly, there must be shown a reasonably close connection between the conduct and the resulting injury. Finally, the plaintiff must show definite damages flowing from the defendant’s negligent act or omission (15).

For the purpose of discussion, consider the following hypothetical scenario. A patient arrives at the ED after 45 min of an ACLS field resuscitation. The initial field rhythm as well as the presenting ED rhythm is asystole. The physician elects to confirm asystole in two separate leads and immediately terminates the resuscitation.

Before analyzing the legal elements involved in the above hypothetical case, a proper risk assessment begins with evaluating some very real world issues. Whether the particular plaintiff legal counsel is a sole proprietor or part of a large law firm, the essential compensation mechanism remains the contingency fee. This type of compensation scheme requires the plaintiff’s attorney to make an early presumptive judgment about the relative merits of the case.

Various factors involved in this assessment include the intrinsic merit of the claim, various evidentiary hurdles, and other non-legal or medical factors. The strongest cases are those in which the facts of the case fit favorably within the framework of historical case precedent.

Most plaintiff attorneys would reject the kind of case presented in the above hypothetical scenario because they would likely view this type of case as one in which the chance of success was extremely low. The following section offers a legal analysis in support of this assertion.

It is worth noting that although attorneys who have a pecuniary interest in winning a malpractice case tend to represent the majority of lawsuits, in many instances, irate relatives often sue without legal representation. Unfortunately, these types of cases tend to drag on the longest and can be quite bizarre.

ANALYSIS OF THE LEGAL ELEMENTS IN THE HYPOTHETICAL SCENARIO

Proving the element of a duty towards the patient would be easily satisfied. From the moment that the patient presents to the ED, there is an implied contract between the physician and patient. In this context, this would presumptively establish the element of duty (16). The difficulty for a plaintiff attorney would be to prove the remaining elements of breach, causation and damages.

To establish a breach, the plaintiff would have to argue that the defendant breached the standard of care by failing to resuscitate the patient. The threshold question, therefore, becomes what is the standard of care for ED resuscitation of patients who have failed advanced resuscitative efforts in the field?

The courts would be likely to interpret the standard of care in this clinical scenario by looking to the custom within the medical profession. Custom is developed over time and represents the clinical practice of physicians within a given specialty. Customary clinical practice is, in turn, typically derived from a recognized body of peer reviewed research. As noted, in the area of resuscitation, there has been a tremendous amount of research that demonstrates the overwhelmingly dismal outcome of this subset of patients (5,8,10,17,18).

Typically, recognized organizations may also inform this process. For example, the American Heart Associa-
tiation (AHA) has indicated that “[r]esuscitation may be discontinued in the pre-hospital setting when the patient is non-resuscitatable after an adequate trial of ACLS” (19). Furthermore, the AHA has stated that, “A finding of cardiovascular unresponsiveness indicates that the heart has died and there is no purpose to be served in evalu-
ating the status of the brain” (19).

According to AHA, the standards of care regarding implementation of resuscitative efforts require that two conditions be met: that there is a possibility of brain viability and that there is no legal or medical reason to withhold it (20,21). As to the first condition, emergency determinations of brain viability are fraught with difficulty. Emergency physicians, therefore, should not rely on this first condition to guide them towards termination of efforts.

As to the second condition, the patient with demonstrated cardiovascular unresponsiveness to aggressive pre-hospital resuscitative efforts provides a compelling example of a valid medical reason to “withhold” further efforts.

For the plaintiff to prevail on the element of a breach in the standard of care, it would have to be claimed that the standard for this subset of patients is to continue aggressive ED resuscitation. This would require that the plaintiff locate an expert willing to testify to this standard.

Although it may be true that in today’s litigious cli-
mate, plaintiff attorneys are often able to produce an expert who will testify to a variety of false standards, the clinical scenario is often one in which reasonable minds can differ. This can produce the situation of the familiar, so-called “battle of the experts.” It is unlikely, in this type of case, that any medical expert could argue credibly for continued resuscitation efforts when the weight of the medical evidence argues against continued resuscitation.

The plaintiff attorney must also consider that the law itself has a mechanism to prevent the use of unreliable expert testimony. The Supreme Court has opined that the trial judge has a general “gate-keeping” obligation to ensure that expert testimony is reliable and credible (22,23). This evidentiary hurdle would likely be one of several factors in an attorney’s decision to reject this type of case.

Even if one were to assume the plaintiff could establish a breach in the standard of care, there would still be enormous difficulty in proving causation and damage. When the alleged injury is death (as in this hypothetical case), the plaintiff must further prove that the defendant negligently caused the death.

With respect to proving causation, the traditional rule has been that the plaintiff must demonstrate that the injury would not have occurred but for the defendant’s conduct (24). The qualitative measurement of this concept has been the familiar “more likely than not” standard. Reduced to a mathematical concept, the plaintiff must prove a greater than 50% chance that the defendant’s act or failure to act caused the injury (25).

Recently, a minority of jurisdictions have used a somewhat relaxed standard of causation referred to as the “loss of chance” doctrine (26). With this doctrine, the plaintiff need only establish that the defendant’s negligence caused a “loss of chance” of recovery or survival (27). In these jurisdictions, the patient no longer has to prove by a preponderance of the evidence that the defendant’s negligence caused the injury. For example, under the “loss of chance” rule, expert testimony would attempt to establish that even though the plaintiff had only a 40% chance of survival, the defendant’s negligence decreased that chance to 10%. The amount of damages awarded would be the difference in those percentages (28).

This doctrine has developed because courts have recognized that in some medical negligence cases, dece-
dents had a less than a 50% chance of living due to their underlying illness (16). This would invariably bar any possibility of recovery for the plaintiff because the defense would argue that the patient would have died anyway from the disorder.

In the above hypothetical scenario, the plaintiff would be unlikely to prevail regardless of the type of cause-
standard the court employed. If the court chose to apply the traditional causation rule, it would be difficult for the court to conclude that “but for” the defendant’s negligence, the injury (death) would not have occurred. This is because the medical evidence simply does not place the plaintiff’s chance of survival at any reasonable percentage (5–8,10).

Even in the minority of jurisdictions using the loss of chance doctrine, the cases in which the court has awarded damages have been those in which the plaintiff had some realistic chance of survival (26). Courts would likely view any damage award in the hypothetical sce-
nario as speculative. Most American courts have a long history of hostility to damage awards based on speculation (29).

CONCLUSION

Many emergency physicians often have vague legal anx-
ieties about getting sued in various clinical scenarios. In the context of resuscitation of the medically futile pa-
tient, this fear seems to be particularly unjustified. Pa-
tients transported to the ED who have already undergone aggressive pre-hospital ACLS intervention and remain in asystole are extremely unlikely to benefit from further efforts. Most emergency physicians know this, yet many continue to perform cardiopulmonary resuscitation and
administer additional ACLS medications for a period of time.

In this situation, physicians should not allow legal anxieties to crowd out medically sound decision-making. A reasonable medical and legally safe approach would be to confirm proper endotracheal tube placement, verify that the cardiac rhythm is asystole, and terminate further efforts (12). The Guidelines note that “...no specific time criteria should be used but that the default approach should be shorter, not longer” (12). The only other required step should be to document all pre-hospital efforts and ED confirmation of such and to make arrangements for a discussion with family members.

Psychological issues or a desire to teach other healthcare workers may also contribute to the physician practice of extending efforts on this group of patients. At times, these may be legitimate. To focus attention on these and other ethical issues, physicians must first recognize that vague legal fears in this situation are not warranted (30).

REFERENCES

26. Illustrious of the jurisdictions that allow for “loss of chance”: