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If Your Heart Stopped Tonight

An ICU physician on taking time to discuss with patients how they see their final days

DANIELA J. LAMAS | OCT 25 2013, 10:31 AM ET

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Dr. Ed Friedlander displays his tattoo with a medical directive to not use CPR, in 2011 (Charlie Riedel/AP)

Nearly 15 years ago, the management of a large company had a novel idea about how to encourage its employees to enroll in 401K savings plans. It wasn't by creating more attractive savings schemes, but by automatically enrolling their employees into the same plans they'd otherwise ignored. The employees could opt or change plans, but few did. Facing a complex decision they were poorly equipped to make, people went with the default option.

Those who study behavior have long recognized the privileged place held by the default—the action taken if a person fails to make a decision. The rules are true in savings plans and car insurance and organ donation. But we consistently and

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—research now suggests—wrongly, assume that when people are posed with questions about death, decision-making should be inherently different.

“Well, I don’t know. If my heart stopped tonight? Do everything.”

My patient was nearly 80 years old and had lung cancer and a pneumonia. I had been a doctor for about a month. It occurred to me one evening, watching her oxygen levels plummet with each paroxysm of cough, that I should probably ask her what she’d want us to do if she got sicker.

“Some patients ask us to do everything,” I told her. “That means electrical shocks, a breathing tube, the ICU. We could do that. Other patients tell us that they don’t want any of this and would prefer just to be comfortable.”

She finally answered: “Well, I don’t know. If my heart stopped tonight? Do everything.”

I made a check mark on my to do list for the evening and thought about the way it feels when ribs break under your hands during chest compressions.

I know that my intentions were good. After all, our intentions generally are. But perhaps our assumptions are flawed, and this is what gets us into trouble. At the University of Pennsylvania, Dr. Scott Halpern, an assistant professor, runs a program that aims to improve end-of-life care by studying how people make decisions. His group recently tested the idea that end-of-life decisions could be influenced by the way options were presented.

They asked more than 100 patients with terminal diseases to fill out one of three advance directives. Two of the sample advance directives had one option already checked off. This was the default—in one the default requested doctors to focus on comfort, the other set asked to extend life at all cost. In either scenario, the patient was free to choose a different option.

My conversations have always assumed that regardless of how I present the information, people should be “immune,” as Halpern says, to the types of bias that plague other decision-making arenas. But that’s not the case. Patients were more likely to elect to receive comfort-oriented care at the end of their lives if that was the default option they were randomly assigned. The default options also changed people’s decisions about chest compressions and breathing machines and feeding tubes.

After all, none of us has died before.

The patients weren’t any different but the default options were and thus, so was the care these groups said they’d want at the ends of their lives.

The words we use matter, too. In another study, out of the University of Pittsburgh, researchers looked at what happened when they changed the way CPR was described. If participants were told that CPR was the norm, more chose CPR. If doctors said that choosing against CPR was in fact the norm, that’s what patients wanted. Shifting language from ‘do not resuscitate’ to ‘allow a natural death’ also changed the participants’ choices.

Faced with a terrifying decision without any history of similar decisions to draw on—after all, none of us has died before—people struggle. Strangers in a strange land, with an array of choices on a page or questions about whether they “want” any one of a horrifying set of technologies, they grasp for guidance



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in a turn of phrase. They read recommendations into the way we carelessly order options. Perhaps autonomy is a false god—and my goal as a physician is instead to know my patients well enough that I can shepherd them toward a treatment path at the end of life that fits with their overall wishes.

“We want to support people’s autonomy to make choices,” Halpern says. “Often that’s a task they can’t accomplish on their own, because they get tripped up. All choices need to be on the table, but we can nudge people toward the ones that are most likely to help them.”

Nothing is scarier than the status quo.

than the status quo.

I left the room that night with my patient’s advance directive in my hand. Full code. I spent the night terrified that each page I got would be about her. The pneumonia would get worse. She would breathe faster and faster and then, tiring, slow gasps until the breaths stopped altogether. The monitor would alarm. We would run in, anesthesia, breathing tube, shocks and intravenous lines in her neck or groin. She would die in the ICU. But that was what she’d chosen, I told myself. After all, I had asked. Right?

It is scary to ‘nudge’ a patient toward an end-of-life decision. But maybe that’s what it means to be a doctor—knowing our patients and helping lead them toward the decisions that are most consistent with their wishes. And nothing is scarier

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