À la carte medicine

he daughter of one of my patients was describing her mother's code status, "She is do-not-resuscitate and do-not-incubate, but it's ok to place central lines and ok to give pressors, but no femoral lines because we have had problems with those in the past — only the neck or under the collarbone. And she really doesn't do well on dopamine, so can we avoid that? I think we should start with levo, then maybe phenylephrine. Are you writing this down?" On my printed sign-out, I summarized, "DNR/DNI, lines OK, pressors OK, prefer Levofed."

The rise of the à la carte code status alarms me. How had this daughter — like so many other spouses, children, siblings and powers of attorney I'd encountered — come to know her mother's preferences regarding the intricacies of critical care medicine? I could never imagine my own father, an engineer, and I having this discussion:

"What are your thoughts on vasopressin, Dad?"

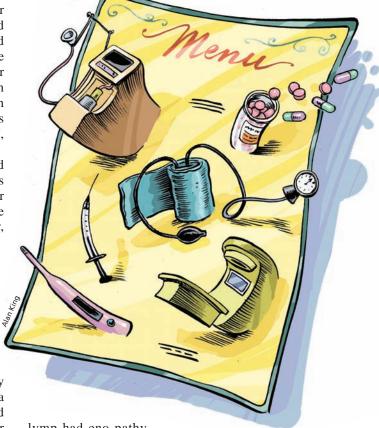
"Oh Son, I'm glad you brought it up. I think I'd prefer levo." "Great choice Dad, you really know the literature."

Picking and choosing among life-sustaining measures is the ultimate example of how we have been plagued with the paradox of choice. More is so often less, and nowhere is this more evident than the intensive care unit (ICU), where trust in the physicians, the nurses and in the hospital is requisite to achieving "good" outcomes. I know that my father, like countless medical citizens, thinks of the ICU as a place where there is only one choice: "Do whatever you need to ... or don't." For him, I know the response is, "whatever you think is best." Studies of patients and surrogates confirm that very few individuals have preferences for specific life-sustaining treatments.¹

Control. It is what we lose when we watch a loved one die, and knowing the details of life-sustaining measures is one way families can grasp at it in the face of eternal uncertainty. I'm not entirely sure that this behaviour is healthy, but I understand how families might be pushed toward it. As a physician, I suspect these micromanaging loved ones are suffering from denial. It's terrible; it's sad; but that said, I don't want to encourage them.

So, why do I keep encouraging them? "It's a lot harder to tell someone they are dying, than to give them more chemo," my hematology/oncology attending once told me. I thought of this as I sat next to my patient's daughter, scrolling through a CT (computed tomography) angiogram of her mother's chest (at the daughter's vehement and repeated request). I was wholly untrained to read the scan, yet she pressed me for details about the progression of her mother's cancer.

Daughter: "Ok, the report said progressions of pe-ri-hil-ar



lymp-had-eno-pathy —

what is that, can you show me?"

Me: "I think that is this. Oh wait, where am I?"

Daughter: "Why is her right lung smaller? What is that?"

Me: "So ... uhhh ... it's actually the left lung that looks smaller, because of that thing, which is the heart — remember, we are looking up from the feet."

Daughter: "The feet! Who told you to do the scan that way?"

The nurse enters the room.

Daughter: "Oh, there you are. Listen, I want to have a word with you. I didn't say you could put an IV in my mother's *right* arm."

Nurse (alarmed): "Doctor, where are you going?"

Me: "Oh, uh, my pager."

Daughter: "I didn't hear ..."

Me: "... on vibrate ... got to run ..."

In the age of à la carte medicine, resistance forces have been relegated to a few hiding places free of surrogate patrol. One such place, however, has been steadily under attack. The operating room. As an internist, I derive secret pleasure from watching my surgery colleagues deal with invasive surrogate decision-makers. Within this culture clash, the encounter seems entirely foreign to both parties.

Patient's son: "How are you going to do the tracheostomy?" Eminent surgeon: "We create an opening here, and connect the ventilator directly..."

Son: "I know that, I mean how *exactly* are you going to do it? Where do you cut?"

Surgeon: "Uh, well, we make a small incision in the neck ..."
Son: "Aren't there important things in the way, like the carotids?"

Surgeon: "Uh, actually ..."

Son: "Will it scar?"

Surgeon: "Excuse me? You mean around the tube?"

Son: "I don't think my mother would want a scar on her neck."

Later, eminent surgeon looks at me with bug eyes. Then, regaining his composure, he says, "Call me when you guys know what you want," and storms off.

Meaning. It's what we lose when we have too much choice. Your mother's death becomes a series of arbitrary and meaningless and ultimately petty preferences, and your mother has been so far removed from "your mother's death," it hardly hurts your anymore. Dying of cancer becomes a series of procedural questions: Are you getting plain old radiation or are you "pummelling cancer with protons"?²

Trust. A doctor who is not trusted is Web-MD. As the facts of medical science become widely available in the information age, trust, more than knowledge, is what makes "my doctor."

Choice. Choices without purpose is rearranging the deck chairs on the *Titanic*, a phrase used no fewer than a dozen times during my last month working in the ICU, and one that seems inadequate to capture the myriad ways we distract ourselves from the grief of watching a loved one die.

À la carte. A menu of items priced and ordered separately is in contrast to a table d'hôte, a set menu at a fixed price. Death, like life, is best experienced with family, with friends and with trust — table d'hôte.

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Editor's note: The people depicted in this article are composites of several patients over time and various places.

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