To the Editor:

We were pleased to learn about the efforts of Gehlbach et al in “Code Status Orders and Goals of Care in the Medical ICU.” We applaud the questions posed by this contribution to CHEST (April 2011), and feel the authors’ framing of these issues raises interesting points for further discussion.

One consideration relates to the decision to combine patients and surrogates into a single population, “patients/surrogates.” While we acknowledge the critical care setting frequently necessitates discussion with surrogates rather than patients, we feel it might be problematic to treat these populations as interchangeable in studying patient preferences and how they differ from code status. Code status orders are usually intended to represent patients’ wishes, not those of surrogates, and a large trial demonstrated that patient and surrogate wishes frequently differ. We wonder whether the recorded discrepancies between preferences and code status might reflect latent differences between patients and surrogates in addition to confusion and miscommunication.

Another point relates to the discussion surrounding discrepancies in goals of care between physicians and patients. The authors conclude that discrepancies exist in 67.7% of cases, but we are curious as to whether they considered that physicians and patients might use different language to express goals that are closely related or even in agreement from a clinical perspective. For example, the results show that patients are more likely to prioritize achieving life goals, whereas physicians are more likely to prioritize prolonging life. These goals appear to overlap in many clinical scenarios, yet this distinction accounts for the two most significant subsets of discrepancies between physician and patient priorities.

Finally, we are curious about the decision to prompt patients, surrogates, and physicians to identify a single goal of highest priority, particularly in framing the relationship between curative and palliative therapy. While it is true that many physicians view these approaches as mutually exclusive, recent studies have indicated a simultaneous care model may provide substantial benefits, including prolonged life. Attending to patients’ comfort may actually help them live longer. We are concerned that framing goals of care in terms of singular priorities risks propagating a notion of care as either palliative or curative and may impede integration of these approaches to patient care. We thank Gehlbach et al for their thoughtful investigation of these issues and their ongoing commitment to the task of improving current practice.

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The Language of Goals of Care

Framing Preferences at the End of Life

To the Editor:

The authors have reported to CHEST the following conflicts of interest: Dr Wahidi was an investigator on the multicenter trial of Fospropofol. Dr Silvestri was an investigator on the multicenter trial of Fospropofol; he was a recipient of grant funding from Olympus America and MGI Pharma for a project assessing fospropofol for bronchoscopy and from Allegro Diagnostics Corp for assessing malignancy in patients with abnormal chest radiographs. Dr Barbour has reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

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Response

To the Editor:

We thank Mr Allen and Dr Jesus for their efforts to engage some of the issues raised by our study. One concern pertains to whether differences between a patient’s code status preference and a surrogate’s understanding of that preference might account for some discrepancies between their expressions of the
patient's preferences and their actual code status orders. First, we agree that surrogate decision making for previously capable adults is expected to follow a standard of substituted judgment so that surrogates represent their loved one's preferences, not their own. Second, it is important to emphasize that when a surrogate served as a participant in our study it was because he/she was the patient's legally authorized decision maker. Whether surrogates' expressions of patients' preferences were accurate, those expressions would in fact serve as the basis for decision making unless a patient's physician had independent knowledge of a patient's previously expressed wishes or had reason to question the validity of a surrogate's decision making.

Regarding the literature-based goals of care we used, we agree that their interrelationships caution against overinterpretation of differences between goals of care identified as most important by physicians as opposed to patients/surrogates. In terms of impact on clinical decision making, there may not be, for instance, a clinically meaningful difference between wanting to achieve a specific life goal vs simply wanting to live longer (though personal significance for patients may vary when a highly valued health goal is at stake).

Last, we agree that different goals of care often are and should be pursued simultaneously. Early in the course of a disease trajectory it is common to pursue cure, longer life, increased function, and comfort. Even in incurable conditions, it is common to pursue cure, longer life, increased function, and comfort. However, it is also true that sometimes some goals of care are mutually incompatible and need to be prioritized, such as when a patient has to choose between comfort (resulting in an earlier death) and cure (resulting in a more burdened life) or between being alert (resulting in the ability to communicate with loved ones) and sedated (resulting in greater comfort and the ability to sleep). Since patients must at times choose between multiple preferred goals, we believe it is sometimes clinically necessary to engage patients in dialogue to learn which goal is most important to them.

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The Value of Chest Ultrasonography in Diagnosing Pneumothorax in Patients With Trauma

To the Editor:

Dr Baumann, in his editorial in CHEST (October 2011), comments on the higher sensitivity of ultrasonography compared with chest radiography in the detection of pneumothorax, as reported in a meta-analysis by Ding et al published in the same issue of the journal. He also suggests that more prospective, randomized studies are needed to demonstrate the comparative clinical effectiveness of ultrasonography. From our perspective as emergency physicians treating patients with trauma, the current available evidence seems to suggest that there is little value in incorporating chest ultrasonography in the evaluation of patients with blunt chest injury.

First, a retrospective study of patients with trauma and occult pneumothoraces (pneumothoraces not identified on chest radiography but diagnosed using thoracic CT imaging) found that 59 patients were managed by observation without tube thoracostomy, of which 51 cases (86%) were successful. For the eight patients in which delayed tube thoracostomy was required, five were placed because of the increasing size of the pneumothorax noted on chest radiography, two were placed prophylactically prior to exploratory laparotomy, and one was placed because of the increasing size of the pneumothorax noted on CT scans. The authors concluded that occult injuries have minimal clinical consequences.

Finally, in a retrospective study of 44 consecutive cases of occult pneumothoraces (same definition as in the previous paragraph) from blunt chest injury in our trauma center in Hong Kong, 36 patients were managed expectantly without significant complications. No pneumothoraces progressed even though eight patients were mechanically ventilated.

Although the sensitivity of ultrasonography in detecting pneumothoraces approaches that of thoracic CT imaging (89% according to Ding et al), these three studies suggest that utilizing chest ultrasonography to detect pneumothoraces that may be missed by chest radiography is likely to have very little impact on improving clinical outcomes in the setting of a contemporary trauma system with modern CT scanners. We agree with Dr Baumann that more high-quality evidence, preferably from prospective randomized studies, is needed to establish the precise role of ultrasonography in this clinical setting, along with its cost-effectiveness, if any.

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