

Anesthesiology
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In Reply.—Dr. Waldman brings out some interesting points in response to my report regarding epidural abscesses associated with epidural catheters.¹

My intent was to report not a controlled study regarding the incidence of epidural abscess, but an event presenting in two separate patients in an unusual time frame (approximately 1 month delay) and possibly associated with placement of epidural catheters in patients who are immunocompromised. Nonetheless, the incidence I report of epidural infection was very similar to that of DuPen *et al.*,² who reported a 4.3% incidence in a series of 350 patients.

Regarding my "interesting technique" of intermittent injections, I noted in my report that continuous infusion would be a more ideal method of delivery of local anesthetic to provide a continuous sympathetic block and pain relief. However, in the military institution where I practice, intensive care unit space and nursing staff are a premium, and we do not feel comfortable leaving patients with continuous epidural infusions of local anesthetics unattended on the ward. In addition, most of our clinic patients are outpatients, and continuous infusions are not feasible. It is noteworthy that we use this intermittent injection technique for surgical patients for postoperative pain control and have not reported a single epidural abscess in more than 10 yr.

Dr. Waldman makes a valid point regarding the risk of prophylactic antibiotics as potentially leading to more drug-resistant pathogens. However, in this instance, the pathogen (*Staphylococcus aureus*) in the first case was very sensitive to the prophylactic antibiotic given (cephradine), and there was not pathogen cultured in the second case. I did note in my discussion that the antibiotics may have contributed to the delay in onset of symptoms.

Finally, regarding epidemiologic factors, I made exhaustive efforts to determine any common factor that may have contributed to both infections, and the only common factor was that both patients received steroids, as noted in the report. There were physicians in common administering the drugs, but none had any infection, to our knowledge. No common equipment was used, and all catheters, syringes and medications given were disposable and used only once.

I appreciate Dr. Waldman's comments, but I hope that the important points in the discussion are not overlooked and that the reported complications are not simply passed off as "bad luck."

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"Do-not-resuscitate" Orders during Anesthesia and Surgery

To the Editor.—The very interesting article by Truog,¹ who argues that do-not-resuscitate orders should be suspended in operating rooms and intensive care units, is incomplete because he does not address patient autonomy. Truog has not discussed the right of patients to autonomous decision making, a right that has been supported by this nation's highest court. Since autonomy is defined as the making of one's own laws, patients have the right to determine when in *the patient's judgment* treatment is not in their best interest.

Truog's conclusion that do-not-resuscitate orders should not remain in effect during anesthesia and surgery is not consistent with the principle of patient autonomy. In his view, anesthesiologists and surgeons have a moral duty to force patients to reject do-not-resuscitate orders within the unique "spatial boundary" of the operating room and the intensive care unit. This "boundary condition" argument presupposes that presence in the operating room or intensive care unit creates a unique set of conditions that override the ordinary concept of patient autonomy.

If physicians take the notion of patient autonomy seriously, they must accept and respect patients' requests for do-not-resuscitate orders even in iatrogenic crises. Patients' decisions cannot be modified by treatment conditions without modifying the definition of autonomy.

Truog seems to hold the generally accepted belief that law forces doctors to be ethical. Our contention is that if physicians were taught to be more comfortable having frank and open discussions with patients

who are about to die, physicians would not have to create the somewhat artificial distinctions between death as a result of treatment interventions and natural death. As a society we seem to have made a fairly direct and unanimous decision: when competent patients have reached a point where they do not want to be resuscitated, they ought to be allowed to die as they wish. We are aware how difficult it must be to let someone die who can be saved, but if we accept Truog's position, we are forced to reject the principle of patient autonomy.

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