Ethical Issues in Critical Care Medicine

Professor Courtenay Bruce
Center for Medical Ethics & Health Policy
• No Disclosures
Objectives

• Identify the impact of futile care and approaches to effectively manage futility in the ICU

• Describe variables which impact personal advance care planning and end-of-life decisions
In 1993, Mr. Barnes executed a healthcare directive appointing his second wife, Lana Barnes, as his medical power of attorney. In the narrative component of his directive, he stated his preferences to forgo life-sustaining treatment (including mechanical ventilation, AN&H, and resuscitation) in the event of a terminal or irreversible condition. He also stated a preference for home hospice. In 1994, Mr. Barnes rescinded the appointment of Mrs. Barnes and named James Barnes, his eldest son from his first marriage, as his agent. Mr. Barnes retained the same language regarding his end-of-life preferences in this new advance directive. James Barnes was never told that he had been appointed his father’s healthcare agent.
• Despite knowing that her husband had withdrawn her authority to act as his agent, Mrs. Barnes told clinical staff that she was his healthcare agent. On December 25, 2010, this 85-year-old man had advanced dementia, dialysis-dependent end-stage kidney disease, and chronic respiratory failure requiring intermittent mechanical ventilation from recurrent pneumonia. He had been hospitalized at least 20 times in the preceding two years at other major hospitals. This was his first admission to hospital A. Mrs. Barnes insisted that his conditions were reversible and she requested maintenance of aggressive treatment.
“Futility” is...
Defining Futility

• What is the purpose in defining futility? Why does defining it matter? What does the concept do for us?

• Is it defined in a way to achieve this purpose?
Defining Futility

- **Physiologic Futility:** Continued treatment is not reliably expected to produce its usually intended physiologic outcome.

- **Imminent Demise:** Cont’d treatment is reliably expected to prevent imminent death (before discharge)

- **Clinical Futility:** Cont’d treatment is not reliably expected to support at least a minimal capacity of the patient to interact with the environment.

- **Functional/Qualitative Futility:** Cont’d treatment is reliably expected to be effective, but also to involve significant disease-related or iatrogenic morbidity, loss of functional status and, therefore, decreased capacity for qualify of life.
Defining Futility

Continued treatment is not reliably expected to produce its usually *intended* physiologic outcome.

- What statistical cutoff point should be chosen as the threshold?
- Even if we could determine statistical cutoff point, physicians are unreliable in their estimates.
- How can you compare patients?
“What constitutes futile care will differ depending on the medical setting, goals for the intervention…In other words, this is a context-dependent and person-dependent assessment….The Council has thus far not directly defined “futility,” a term whose meaning inherently involves a value judgment…The Council recommends defining futility on a case-by-case basis, taking full account of the context and individuals involved; it proposes a due process approach to achieving this case-by-case definition.”
“Due Process” Means.....
## Negotiate Disagreements

### Interpersonal Tensions | Manifestations | How to Address It
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**Burden of decision-making**

- “What are you hoping to see in this meeting?”
- “What is making this particularly challenging for you?”

1. Make it family-centered
2. Focus on patient values and goals
3. Offer to defer decision making

**Family obligations and pressures**

- Watch body language

1. Give them space
2. Work one-on-one

**Desire for recovery**

- See them struggling with the decision making and ask them

1. State the probabilities
2. Call out uncertainty where it exists
3. Offer time-limited trials
<table>
<thead>
<tr>
<th>Poor Word Choice</th>
<th>How it May be Perceived</th>
<th>Excellent Word Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>“We will make it so that X does not suffer”</td>
<td>“We are going to kill X.”</td>
<td>“We will do everything we can to allow for a comfortable and peaceful passing.”</td>
</tr>
</tbody>
</table>
| • “Let’s stop aggressive treatment.”  
  • “We are recommending withdrawal of treatment.”  
  • “We need to stop active treatment.” | “We will not take care of him at all.” | “The goal of X intervention was to…But, despite efforts of a lot of people and a lot of time to see if recovery was possible, we’ve learned recovery is not possible. We are so sorry and wish that it was different…” |
| • “Do you want us to do CPR?”  
  • “Do you want us to stop treatment?” | “You are the final arbiter of your loved one’s death.” | “Let me tell you about CPR…If her heart were to stop it would be because she’s dying…Pumping on her heart will not make her better.” |
And if negotiation does not work.....
“If [after extensive negotiation] disagreements are unresolvable, [resort to] the hospital policy on medical futility...[which may involve] an institutional committee such as the ethics committee.”

Opinion 2.037 - Medical Futility in End-of-Life Care
• Ethical justifications for refusing to comply with “futile” treatment requests:
  – A belief on the part of clinicians that continued treatment would be “medical inappropriate” and therefore violate professional integrity.

  OR

  – A belief on the part of clinicians that continued treatment is both appropriate and necessary and that cessation of it (at the request of the surrogates) would violate professional integrity.
Conflicts at the End of Life

- **Type 1: Conflict between pt/family & health care provider(s).**
  A. Pt/family want to withhold or withdraw life-sustaining treatment and the health care provider(s) don’t.
  B. Health care provider(s) want to withhold or withdraw life-sustaining treatment and the pt/family don’t

- **Type 2: Conflict between family members**
  - Family members disagree about withholding or withdrawing life-sustaining treatment

- **Type 3: Conflict between clinicians**
• Decision of attending physician not to honor a directive or treatment decision shall be reviewed by a medical or ethics committee.
• 48-hour notice to patient/surrogate and right to attending meeting.
• Written explanation of decision reached to patient/surrogate and in record.
• Reasonable effort to transfer patient if attending, patient, or surrogate does not agree with the decision of committee.
• If attending refuses to carry out request for life-sustaining treatment and committee support his or her refusal, then treatment can be discontinued on the 10th day after the written decision is given to patient/surrogate.
• Extension granted only if judge determines there is a reasonable likelihood of finding a willing provider.
256 Cases

Review Committees disagreed with physicians

256 Cases

Review Committees agreed with physicians

178 Cases (With 265 reported outcomes)

Before the end of 10 days (187 reported outcomes)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Died</td>
<td>78</td>
</tr>
<tr>
<td>Patients / Representatives agreed to discontinue treatment</td>
<td>71</td>
</tr>
<tr>
<td>Patients Transferred</td>
<td>30</td>
</tr>
<tr>
<td>Patients Improved</td>
<td>8</td>
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After the end of 10 days (78 reported outcomes)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Discontinued</td>
<td>33</td>
</tr>
<tr>
<td>Treatment Continued</td>
<td>45</td>
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</tbody>
</table>

Smith ML, et al. (2007)
<table>
<thead>
<tr>
<th>What type of decisions does it apply to?</th>
<th>End-of-Life decision-making</th>
<th>Any health care decision</th>
<th>Resuscitative efforts</th>
</tr>
</thead>
<tbody>
<tr>
<td>When does it become operable?</td>
<td>After the patient loses capacity AND is in a terminal or irreversible condition</td>
<td>After the patient loses capacity</td>
<td>Out-of-hospital setting and patient has an arrest</td>
</tr>
<tr>
<td>When is it completed?</td>
<td>When the patient has capacity</td>
<td>When the patient has capacity</td>
<td>When patient has capacity; surrogate can complete on behalf of patient w/o capacity</td>
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<tr>
<td>Benefits?</td>
<td>Communicates treatment decisions re. life-sustaining therapies</td>
<td>Good to use when you want to appoint someone outside of the surrogacy hierarchy</td>
<td>Guides EMS about patient’s treatment preferences</td>
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<td>Drawbacks?</td>
<td>Lacks Specificity; wishes expressed may not be current</td>
<td>Assumes the MPOA is willing and able to make decisions in accordance with patient wishes</td>
<td>Resuscitation will occur if document is unavailable.</td>
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<tr>
<td>Ethical Consensus</td>
<td>Lack of Consensus</td>
<td></td>
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<td>----------------------------------------------------------------------------------</td>
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<tr>
<td><strong>General Rule</strong></td>
<td>Few professional statements clarify when or how a physician may legally withdraw or withhold life-sustaining treatment</td>
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<td>Physicians are not obligated to provide treatments to patients that they believe are harmful or ineffective.</td>
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<td><strong>Medical Futility Process</strong></td>
<td>Should ethics committees be able to unilaterally withdraw life-sustaining treatment against the wishes of the patient or family?</td>
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<td>Cases of medical futility should be evaluated individually using a case-based approach.</td>
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<td><strong>Communication strategies</strong></td>
<td>Who is best equipped to mediate?</td>
<td></td>
<td></td>
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<tr>
<td>Try mediation and communication first</td>
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<td><strong>DNR orders</strong></td>
<td>Should unilateral DNRs be considered appropriate?</td>
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<td>Directive approach is appropriate</td>
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<td><strong>Patient preferences</strong></td>
<td>What should be done when surrogate decision makers make decisions that are arguably against patient preferences?</td>
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<td>Elucidate patient wishes; define goals early</td>
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Questions

• There is a single definition of futility that can be applied to every case
  – A. True
  – B. False
Which of the following is not an advance directive here in Texas?

- A. The living will, also known as the directive to physicians
- B. The out-of-hospital do-not-resuscitate order
- C. The POLST form
- D. The medical power of attorney