Ethical Issues in Critical Care Medicine

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- 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

Case Example

- 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 Barnes rescinded the appointment of Mrs.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.

Case Example

- Despite knowing that her husband had withdrawn her authority to act as his agent, Mrs.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…

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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?

Defining Futility

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"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."

Opinion 2.037 - Medical Futility in End-of-Life Care

“Due Process” Means….

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Negotiate Disagreements

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Interpersonal Tensions	Manifestations	How to Address It
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

Poor Word Choice	How it May be Perceived	Excellent Word Choice
"We will make it so that X does not suffer"	"We are going to kill X."	• "We will do everything we can to allow for a comfortable and peaceful passing."
• "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…..

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Due Process

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"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 Bases for TADA, 166.046

- 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

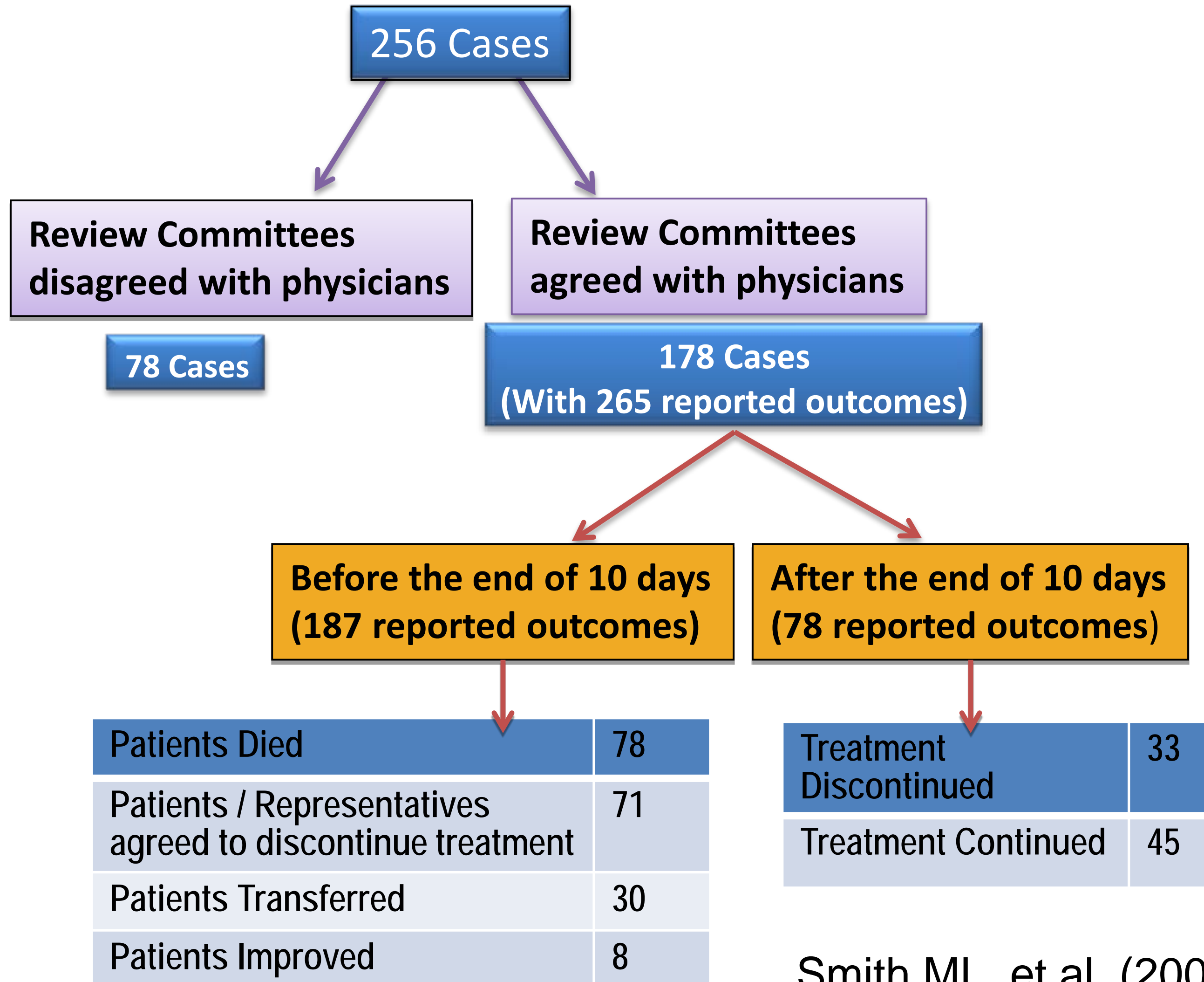
- **Type 2: Conflict between family members**
    - Family members disagree about withholding or withdrawing life-sustaining treatment

- **Type 3: Conflict between clinicians**

TADA, Section 166.046 **

- 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.

Texas Hospitals' Experience



Smith ML, et al. (2007)

	Directive to Physicians	MPOA	OODNR
What type of decisions does it apply to?	End-of-Life decision-making	Any health care decision	Resuscitative efforts
When does it become operable?	After the patient loses capacity AND is in a terminal or irreversible condition	After the patient loses capacity	Out-of-hospital setting and patient has an arrest
When is it completed?	When the patient has capacity	When the patient has capacity	When patient has capacity; surrogate can complete on behalf of patient w/o capacity
Benefits?	Communicates treatment decisions re. life-sustaining therapies	Good to use when you want to appoint someone outside of the surrogacy hierarchy	Guides EMS about patient's treatment preferences
Drawbacks?	Lacks Specificity; wishes expressed may not be current	Assumes the MPOA is willing and able to make decisions in accordance with patient wishes	Resuscitation will occur if document is unavailable.

	Ethical Consensus	Lack of Consensus
General Rule	Physicians are not obligated to provide treatments to patients that they believe are harmful or ineffective.	Few professional statements clarify when or how a physician may legally withdraw or withhold life-sustaining treatment
Medical Futility Process	Cases of medical futility should be evaluated individually using a case-based approach.	Should ethics committees be able to unilaterally withdraw life-sustaining treatment against the wishes of the patient or family?
Communication strategies	Try mediation and communication first	Who is best equipped to mediate?
DNR orders	Directive approach is appropriate	Should unilateral DNRs be considered appropriate?
Patient preferences	Elucidate patient wishes; define goals early	What should be done when surrogate decision makers make decisions that are arguably against patient preferences?

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

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