Ethical Issues in Acute and End-of-Life Care

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LEARNING OBJECTIVES

 Identify the ethical issues facing patients during acute and end-of-life care
 Name the basic principles of medical ethics
 Understand the basics of advance directives
 Know the hospital’s process for ethics resolution

It’s Never an Easy Choice
**ISSUES AFFECTING CARE**

- An aging population
- Lack of available family and community caregivers
- Increase in the fear of litigation
- Lack of knowledge about appropriate treatment
- Availability of high tech interventions
- Access to hospice services

**Quick Legal Review**

- Karen Quinlan, 1976: The right to privacy and the appointment of surrogates as end of life decision makers
- Nancy Cruzan, 1990: The right to refuse treatment if there is clear and convincing evidence
- Patient Self Determination Act, 1991
- JCAHO, 1992: Required formal mechanism for addressing ethical issues
- Terry Schiavo, 2005: Husband wins court battle to have feeding tube removed after years of battle

**BIOMEDICAL ETHICAL PRINCIPLES**

- Autonomy
- Beneficence
- Non-maleficence
- Veracity
- Justice
AUTONOMY
- The driving force of self determination
- Patient has the right to make decisions about treatment according to beliefs, culture, personal values and life plan

BENEFICENCE
- Always act in the best interests of the patient
- Promotion of the patient’s well-being

NON-MALEFICENCE
- Avoid doing harm to the patient
- Respects the inherent worth and dignity of every patient
- Avoid treatments or interventions that would do harm
**VERACITY**

- Truth telling
- How much do you tell?
- How much does the patient want to know?
  - Cultural considerations

**DISTRIBUTIVE JUSTICE**

- Fair allocation of resources
  - Transplant world
  - Need for ICU beds
- "Death panels"

**INFORMED CONSENT**

- Necessary for all treatment
- Must be voluntary
- Pt must understand
  - The nature of his or her condition
  - The possible benefits and risks of the recommended treatment
  - Alternative treatments and their possible risks and benefits
  - The prognosis if the condition is left untreated
DECISION-MAKING AUTHORITY

- Capable patients make their own decisions
- Specific advance directives are recorded in medical records
- Judgment of surrogate decision makers
- Use ethics committee members when there is no family

CAPACITY VS. COMPETENCY

- Capacity is the patient’s ability to make his or her own decision
- Competency is a legal term; a judge determines competency
- Paradox of capacity—the problem is the tendency to believe that a patient is rational or capable if he or she agrees with our judgment

ADVANCE DIRECTIVES

- Two part document:
  - Living will
  - Health care proxy
- Certification of Healthcare Surrogacy
- Durable power of attorney for healthcare
- Court appointed guardian
SURROGATE

- “Certification of Healthcare Surrogate” on SPP/SCR
- Patient lacks decisional capacity and has no advanced directive
- Designated hierarchy of decision making authority
- Does not require “proof”; surrogate’s signature implies agreement among family that he/she is the designated healthcare proxy

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

- Appointment of a decision-maker
- Completed while patient has capacity
- Goes into effect when patient loses capacity
- Responsibilities and rights
- Durable power of attorney trumps an advance directive
COURT-APPOINTED GUARDIANS

- Guardianship vs. conservatorship
- Ward of the state
- Alternatives to guardianship
- Court appointed guardians do NOT make end-of-life decisions
  - i.e., DNR, withdrawal of life support
  - Ethics committee can be consulted at this time

Advance Planning

- Ongoing Process
- Ongoing Discussions
- More focus on values and preferences
- Holistic
  - Physical
  - Emotional and Social
  - Spiritual
- Communicating the meaning in our lives to our family

BARRIERS TO COMPLETION OF ADVANCE DIRECTIVES

- Fears
- Denial
- Discomfort with strong emotions
- Needing to save or rescue patient/family
- Cultural
- Personal beliefs of health care workers
MORE BARRIERS...

- Fear of not being able to set and maintain healthy boundaries
- Personal experiences with dying and death
- Inadequate training in end of life care
- Amount of professional mentoring and support
- Ability to manage compassion fatigue

WITHDRAWING/WITHHOLDING/REFUSING TREATMENT

- Evokes complex ethical questions
- Includes CPR, ventilators, artificial nutrition and hydration, dialysis, antibiotics, pacemakers, blood
- Ethically appropriate if:
  - The patient or surrogate requests treatment be withheld (does not give informed consent) or requests that it be stopped (withdraws consent)
  - The treatment is medically ineffective or inappropriate
  - The treatment will not achieve the patient’s health goals

"Medical ethics do not allow me to assist in your death. I am, however, permitted to keep you miserable as long as possible."
CARDIOPULMONARY RESUSCITATION

- Around 15% of hospitalized patients survive to discharge with CPR
- Virtually no survival to discharge for patients with:
  - Overwhelming pneumonia
  - Renal failure
  - Acute stroke
  - Multiple organ failure

CPR. CONTINUED...

- 25-50% of patients resuscitated have:
  - Fractured ribs
  - Fractured sternum
  - Aspiration pneumonia
  - Hemorrhage
  - Pulmonary edema
- “Slow codes”
  - Bypasses patient’s rights
  - Puts an unfair responsibility on nursing staff

DNR ORDERS AND FUTILITY

It is ethically acceptable for a physician administering CPR to cancel or refuse to initiate when:
  - It is not medically appropriate in that it is not likely to be successful
  - It would harm the patient with no likely benefit
  - It will not achieve the patient’s goals
MEDICAL FUTILITY

- Conflicts arise regarding beliefs of the beneficial nature of a treatment
- Often involves failure of communication
- Religious and cultural factors must be considered
- Post-hoc futility—treatment has been tried and has failed
- Predictive futility—predicts that treatment will be futile and therefore should not be tried

PRINCIPLE OF DOUBLE EFFECT

- Involves taking an action intended to have a good effect, but the consequence is a known potentially harmful effect
- According to the ANA, administering medication for pain control for a terminally ill patient is ethically justified even if the secondary effect is to hasten death
EUTHANASIA VS. PHYSICIAN ASSISTED SUICIDE

- Euthanasia—causative agent of death is directly administered by another
- Physician assisted suicide—causative agent of death is provided to the patient, who administers it to himself
- PAS legal in Oregon, Washington, Vermont, New Mexico and Montana
- 93% of people who chose PAS in Oregon were hospice patients

Jonsen’s Four Box Framework: Case-Based Reasoning

- Medical indications
- Patient preferences
- Quality of life
- Contextual features

MEDICAL INDICATIONS

- What is the patient’s medical problem? History? Diagnosis? Prognosis?
- Is the problem acute? Chronic? Emergent? Reversible?
- What are the probabilities of success?
- What are the plans in case of therapeutic failure?
PATIENT PREFERENCES

- Assess knowledge of current situation, then ask:
  - Have prior preferences been expressed by the patient?
  - Who is the designated decision-maker for the patient?
  - Is the patient unwilling or unable to cooperate with the medical treatment?
  - What are the patient and family’s hopes for treatment?
  - What would the patient and/or family find to be helpful right now?

QUALITY OF LIFE

- What are the prospects, with or without treatment, for a return to normal life?
- What physical, mental, and social deficits is the patient likely to experience if treatment succeeds?
- Are there biases that might prejudice the provider’s evaluation of the patient’s quality of life?
- Is the patient’s present or future condition such that his/her continued life might be judged undesirable?
- Is there any plan and rationale to forego treatment? Are there plans for comfort and palliative care?

CONTEXTUAL FEATURES

- Are there family or provider issues that might influence treatment decisions?
- Are there financial and economic factors?
- Are there religious or cultural factors?
- Are there problems of allocation of resources?
- How does the law affect treatment decisions?
- Is there any conflict of interest on the part of the providers or the institution?
Do You Know This Woman?

The meaning of life and death... who decides????
**SCHWARTZ ROUNDS**
- Interdisciplinary format to examine ethically challenging cases
- Every 4th Friday (except November and December)
- Lunch ready at 11:00 am, rounds 11:15-12:15
- Margaret Cameron Spain Auditorium
- Continuing education credit

**ETHICS CASE CONFERENCES**
- 1st Tuesday of every month, 4:30-5:30 pm
- WPCC-A
- CEU & refreshments provided
- Different cases examined
  - Bioethical principles
  - Ethics committee line of reasoning in resolution

**CONCLUSIONS**
- Ethical dilemmas are inevitable in acute care
- Health care professionals are required to abide by their Codes of Ethics
- Ethics committees exist to help resolve ethical dilemmas
- It is imperative to separate out our own values and morals
- People have the right to make their own decisions, even if they are “bad” decisions
- Health care professionals are obligated to advocate for the patient and family
Lakota Indian Philosophy

- Show up
- Be present
- Tell the truth
- Let go of the outcome