Ethics in Intensive Care Unit

DR ROZAINI.BH
ANAESTHESIA IJN
Disclosure

- No relevant disclosures

- I am not a lawyer and this presentation does not constitute legal advice
Objectives

- Understand the concepts of decision making capacity, advanced directives and lasting power of attorney as they apply to intensive care patients
- Use four principles of biomedical ethics to guide your decision making in ICU and understand the limitations of these principles
- Conflicts in intensive care
Introduction

- Ethical problems are prominent in ICU because the stakes are high and gains uncertain.
- ICU can provide potentially life treatments to critically patient however some are not survive.
- Most of ICU patients unable to participate in decision making therefore physician need to determine what are the ethical treatments to patient.
Ethics are

- Ethics is a study of how one ought to behave.
- In contrast, the law define how one must behave to avoid punishment.
- Ethics is concerned with differentiating right from wrong behavior.
Ethics definition

- Standard of behavior that tell us how human beings ought to act in the many situations in which they find themselves as friends, parents, children and society
Patients are entitled to good standards of practice and care from their doctors.

Essential elements of these are professional and competence, good relationships with patients, colleagues and observance of professional ethical obligations.

Whosoever kills human being (except as punishment) it shall be like killing all humanity and whosoever saves a life, saves the entire human race ...

Al Maidah :32
Ethical Principles
Ethical Principles

- **Autonomy**
  - Self governance, respecting and supporting autonomous decision

- **Beneficence**
  - Promoting benefit

- **Non maleficence**
  - Avoiding harm

- **Justice**
  - Fairly distributing benefits, risks and costs
Ethical Principles

Patient autonomy

Distributive justice

Beneficence and nonmaleficence

patients, families and surrogate decision makers

Society, communities and government providers and their institutions

Health care
Autonomy

- **Autonomy**: Respect for an individual’s autonomy or ability to make decisions for him/herself.
- Patient must competence and has capacity to make decision

Criteria for adequate decision making:
- Ability to comprehend information relevant to decision
- Ability to compare alternatives of decision with personal values and goals
- Ability to communicate in a consistent and meaningful manner
Beneficence, Non-maleficence

- **Beneficence:**
  - This refers to the tradition of acting always in the patients' best interest to maximise benefits and minimise harm.
  - Do good to patient

- **Non-maleficence:**
  - This principle ensures that treatment or research ought not to produce harm
  - Do no harm
**Justice**

- **Justice**: This refers to the need to treat all patients equally and fairly.
- Allocating resources appropriate to medical condition of patient in order to maximize their benefits and minimize wastage.
- Futile application of therapies would clearly violate this obligation.
**Ethical Principles**

- Clinicians use these principles in assisting patients to make the right decisions for themselves.

- Each of these concepts are rarely used alone, but balance each other to guide an ethical conduct of care.
Decision Making in ICU
Criteria for adequate decision making

- Ability to comprehend information relevant to the decision
- Ability to compare alternatives of decision with personal values and goals
- Ability to communicate in a consistent and meaningful manner
Other countries: POLST
Malaysia:
22% of all US deaths occur in the ICU
90% of ICU deaths occur after the decision to withdraw life support
95% of ICU patients are not capable of autonomous choice

White et al CCM 2006:34: 2053

Who make decision for this patients?
In one study of patients without either decision making capacity or surrogates, 89% decision were made by physician without institutional or judicial review
Scenario 1

- 77 yr old man, admitted to ICU following ruptured of cerebral aneurysm
- After 2/52 on ventilator dependent and inconsistently response to simple command (squeeze my hand)
- He lives alone and has no advance directive
- His son is in Australia with whom has not communicated in five years
- He has several friends at nursing home, whom he regular socialize
Depending upon state law each of the following maybe acceptable, except

A) The clinical team may make decision for him using a best interest situation
B) The patient’s son may make decision for his father as he legally authorised surrogate
C) The clinical team may consult with hospital ethics committee and patient’s friends to make decision for him
D) The clinical team may seek appointment of a guardian for decision making
Standard for surrogate decision making

- Substituted judgment standard
  - Advance directives –living wills (eg; POLST)
  - Durable power of attorney for health care
- Best interest standard
  - Vague often consistent with a wide range of options
  - ICU patients who are medically identical may therefore be treated in very different ways (active vs palliative)
Advance Directives

- A general term used to describe the documents that give instructions about future medical care treatments

- Advance directives include:
  - Living will – eg POLST form
  - DNR order
  - Withholding or withdrawing treatment
Durable power of attorney for health care

- A term used by some states to describe a document used for listing the person or persons to make health care decision should a patient become unable to make informed decision for self.

- Person appointed may called a health care agent, surrogate, attorney in fact or proxy.
Who is the surrogates?

- Typical rank of order:
  - Spouse
  - Adult child
  - Parents
  - Adult sibling
  - Grandparents
  - Adult grandchild
  - Adult close friend
  - Attending physician
Conflicts in ICU
Today’s complexity of technology in modern health care, value heterogeneity, individual rights all contribute to conflicts in intensive care management.

Conflicts may occur in:

- Between ICU team and family; 44%
  - 85% family wishing ‘team’ to be more aggressive
  - Within family members 57%
  - Within ICU team 7%

Studdert DM et al: Conflicts in critical care of patients with prolonged stay in ICU. Intensive Care Medicine 2003;29
Conflicts

No conflict
- No changes and little motivation
- Optimal amount of conflicts will generate
  - Creativity
  - Strong team spirit
  - Motivation

Abundant conflicts
- Loss of energy
- Decreasing productivity
- Increasing stress
- Burn out syndrome
- High turn over
Source of conflict

- Poor communication
- Life Sustaining Therapy preferences (goal of therapy, level of care)
- The decision making process (inability or unavailability of family decision maker)
- Coping problems (psychological support)
- Expected outcomes
- Symptoms control
- Staff behaviour (verbal abuse, unprofessional)
- Lack of leadership and coordination
- Mistrust
Impacts of ICU conflicts

1. Patient’s preference and values are not respected
2. Family dissatisfaction and conflicts with family members
3. Decision making process is not ethically acceptable
4. Non effective interventions aimed at improving EOL care
5. Burn out syndrome
Engaging with families

- RCT of impact of proactive EOL conferences and informative brochures
- Intervention resulted
- Longer family meeting (30 minutes vs 20 minutes)
- Family spend more time talking (14 minutes vs 5 minutes)
- Intervention resulted in a lower prevalence in the families of
  - PTSD 45% vs 69%  \( p = 0.01 \)
  - Anxiety 45% vs 67%  \( p = 0.02 \)
  - Depression 29% vs 56%  \( p = 0.03 \)

(Schneidermann et al, JAMA 2003 : 1166)
Scenario 2

- 44 years old man. Has prosthetic aortic valve and subsequently required a pacemaker for 3\textsuperscript{rd} degree heart block.
- He is poorly adherent to his anticoagulant regime and suffers multiple embolic strokes over the few years, leaving him unresponsive.
- His wife requests disabling of the pacemaker on grounds that the patient would not choose to continue living in this condition.
Which answer is correct?

a) PM must be continued since internal treatment cannot be legally withdrawn
b) The PM must be continued since stopping it would be euthanasia (illegal)
c) PM cannot be discontinued without court order
d) PM may be discontinued as wife is the patient’s legal surrogate
e) PM must be continued but battery can be allow to expire without replacement
Futile Treatment
Futility

- A situation in which providing treatment produces burdens which far outweigh benefits in providing that care.

- Implementation of any treatment that cannot achieve a therapeutic benefit for the patient in light of the patient’s overall status and life goals.
Withdrawal or withholding life-sustaining treatment on basis of futility:

- **Futile**: “…cannot be expected to restore or maintain vital organ function or to achieve the expressed goals of the patient when decisional.”

- **Includes**: “CPR, mechanical ventilation, artificial nutrition and hydration, renal dialysis, blood products, vasopressors, or any other treatment that prolongs dying.”

- “Appropriate palliative care measures should be instituted.”
Demands for futile treatment

- Physicians have no obligation to provide treatment that offer no benefit (futile treatment)
- Provide futile care is a major source of burnout among ICU clinicians and nursing

But;
- Wide disagreement on what counts as futile
- Scoring systems (eg: APACHE score) designed for populations, not individual prognostication
- Multiple studies show eliminating futile care will not save significant money
Allocating Resources
Allocating limited resources

- ICU consumed a significant proportion of health care budget
- Raise concerns about the fair and efficient distribution of medical resources

- Some thought:
  - You can’t put price on human life...
  - There is a right to health...
  - There is a right to health care
Problems with the right to health and healthcare

- Everything has a price...
- Can a right to health exist if there is no reciprocal obligation on a doctor to keep someone healthy
- Therefore, if there is a right to healthcare, it is limited...
Withdrawal or withhold of life sustaining treatment
Withdrawing treatment is a difficult decision because prognostication is uncertain and patient cannot be consulted.

Legally, physicians are not obliged to provide or persist with futile treatment.

Eg: mechanical ventilator
- Maintain physiology level CO2 - not futile
- Expect recovering independent function - futile
Communication with family about withdrawing of treatment required:

- Repeated sensitive discussion
- More days

ICU physician should highly competence at providing EOL care
Advance Care Planning

- Getting information on treatment options
- Deciding on treatment preferences
- Getting information on how disease or serious illness might progress
- Discussion with patient and family about treatment goals, risks, benefits
- Sharing personal values with loved ones
- Using AD to put into writing preferences about life-sustaining treatment specific to the patient
A step-wise approach withholding/withdrawal of life support

1. Determine if ICU patient has a decision making capacity
2. Determine if the patient expressed her preferences for medical care before ICU admission
3. Establish trust and effective communication with surrogate and other family members
4. Confirm that the goals of therapy early after ICU admission are appropriate
5. Continue to convey to surrogates and family the patient prognosis and its uncertainty
6. Base on recommendations for further care on as complete an understanding of patient's medical condition, prognosis and preferences
End Of Life care
Patients are ‘approaching the end of life’ when they are likely to die within the next 12 months including patients whose death is imminent (within a few hours or days) and those with:

a) advanced, progressive, incurable conditions.
b) general frailty and coexisting conditions that mean they are expected to die within 12 m
c) existing conditions if they are at risk of dying from a sudden acute crisis in their condition

d) life- threatening acute conditions caused by sudden catastrophic events.
EOL care in the ICU

- EOL care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die.
- It enables the supportive and palliative care needs.
- It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.
Death in ICU is “common”

- Mortality rate: ~20% in USA, ~15% in France, 10-20% in Canada, 15-20% in Scotland. Therefore just as important as other aspects of ICU care.

- Life-sustaining treatment sometimes provides no net benefit to patient and may even subject them to harms and burdens of the treatment.

- It strike a balance between humane care and active intervention at the end of life.

- Our responsibility as doctors and nurses to “take care that a patient dies with dignity and with as little suffering as possible”
Critically review, the need of cardiac monitoring!!

Critically evaluate all ICU therapies: Are they making a net positive contributions to comfort of the patient? Antibiotics, vasoactive drugs, dialysis, ventricular assisted devices, IV fluids, nutrition

No need for ‘weaning’ of treatment (excluding mechanical ventilation) such as antibiotic, blood products, IV Fluid. They can be abruptly stopped

To extubate or not to extubate- no consensus
Recommendations

- Adherence to 7 key domains for quality improvement at EOL:
  - Patient and family centered decision making
  - Communication
  - Continuity of care
  - Emotional and practical support
  - Symptom management
  - Spiritual support
  - Emotional/organizational support for ICU clinician
The role of the physician

- Explaining and informing on the illness/disease process – to patient and proxy
- Discussion of pain management options
- Learning the patient’s views on quality of life, role of spirituality/religion
- Working out the details of how the plans will be carried out
- Education and discussion on hospice and palliative care
Niv in eol care

- SCCM task force: clearly identify the goal of the treatment
  - NIV as life support with no preset limitations on life sustaining treatment
  - NIV as life support when patient and family have decided to forego endotracheal intubation
  - NIV as a palliative measure when patient and family have chosen to forego all life support receiving comfort measure only

(Curtis JR et al CCM 2007 35:932)
Rule of Double Effect
This is used to support acts that may have two effects, one intentional and the other possible, but not intentional.

Four conditions justify an ethically permissible act:
- The act must be beneficial.
- The person carrying out the act must intend only the good effect.
- The bad effect must not be a means to the good effect.
- Benefits of the good effect must outweigh those of the bad effect.
Administering medication to relieve pain and suffering which may also produce decreased respirations and hasten time of death.
DO NOT ATTEMPT RESUSCITATION (DNAR)
Do not attempt resuscitate order

- No CPR
- Withholding and withdrawing life sustaining therapy
  - Mechanical ventilator
  - Vasopressor
  - Dialysis
  - Antibiotics
  - Fluid
  - Blood products
  - Parenteral nutrition
<table>
<thead>
<tr>
<th>Level</th>
<th>Definition of Therapy</th>
<th>Description and Goals of Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>All therapies but no CPR</td>
<td>The patient will be treated as medically indicated, including all efforts to prevent cardiac or respiratory arrest. However, if such an arrest occurs, no resuscitative efforts will be made. This order should be reviewed prior to all operative procedures and may be temporarily suspended during or immediately after such procedures based on outcome of discussions by members of the operative team and the patient (or surrogate decision maker).</td>
</tr>
<tr>
<td>B</td>
<td>Limited therapy; no CPR</td>
<td>Therapy already begun will be continued as medically indicated. In general, no additional treatment will be added except for providing comfort to the patient. If cardiopulmonary arrest occurs, no resuscitative efforts will be made.</td>
</tr>
<tr>
<td>C</td>
<td>Comfort measures only</td>
<td>Treatment will be limited to nursing and medical therapy appropriate for hygiene and comfort. In general, treatment needed for comfort will be given even if it depresses cardiac or respiratory function. Life-sustaining therapies already started may be discontinued by written order.</td>
</tr>
</tbody>
</table>

What Patients Care About When Making ACP Decisions

- Dialysis patients have identified the following as important:
  - Receiving adequate pain and symptom management
  - Avoiding inappropriate prolongation of dying
  - Achieving a sense of control
  - Relieving burden on loved ones
  - Strengthening relationships with loved ones

The nurse’s responsibilities

- Be aware of legal issues and wishes of the patient
- Nursing care of dying patients is holistic and encompasses all aspects of psychosocial and physical needs
- Focus on patient and family: respect, dignity and comfort
- Recognize own needs when dealing with grief and dying

2. Ethical principles in end-of-life decisions in different European countries Jean Louis Vincent Swiss Medical Weekly

3. Medical Law, Jo and Ash Samantha, Palgrave Macmillan Law Master