Objectives:
- Review Ethical Decision Making
- How to address Goals of Care
- How to Communicate Bad News
- How to address Code Status
- Approach to the withdrawal/withholding of life sustaining treatment – ventilator withdrawal
- Withdrawal/withholding artificial nutrition/hydration

Ethical Decision Making:
- **Non-maleficence** – Do No Harm
- **Beneficence** – Your goal is to achieve a benefit which the patient can appreciate
- **Patient Autonomy** – Must be guided by patient’s wishes even after the patient has lost decision making capacity (Advance Directives)
- **Distributive Justice** – Allocating limited resources in a fair manner

Translating Basic Ethical Principles to daily clinical decision making...

Based on the concept of **Beneficence**, we understand that the goal of medicine is to benefit the patient.

What is the benefit we are hoping to achieve, what are our **goals of care**??
Addressing Goals of Care:
- Cure
- Prolongation of Life
- Alleviate Suffering/Comfort Care

When Cure is no longer achievable:
- Our focus becomes prolongation of life (managing a chronic progressive disease)
- Prognostication is vital in helping the patient/family make decisions
- When does the burden of treatment outweigh any potential for benefit? Who decides?

When Prolongation of Life is no longer achievable or desirable...
- We shift our goal to alleviation of suffering/comfort care
- How do we define comfort care?
  - Antibiotics?
  - Transfusions?
  - ICU?

Language with unintended consequences:
- Do you want us to do everything possible?
- Will you agree to discontinue care?
- It's time we talk about pulling back
- There is nothing more we can do
Helpful Language....
- I will focus my efforts on treating your symptoms
- I want to ensure that you receive the kind of treatment you want
- Your comfort and dignity will be my top priority

Estimation of Prognosis
- Prognostication is a tool to help us determine our goals – preservation of life vs. providing a "good death"
- Objective measures such as APACHE and MPM (Mortality Prediction Model) develop to reduce biases in predicting outcomes.

Dealing with Uncertainty
- Physician discomfort with uncertainty may be a major barrier to good end of life care
- Most common response to uncertainty is avoidance – focus on details, ignore the big picture (Rearranging chairs on the Titanic)

Communicating Bad News....
1. Proper Setting – quiet, privacy, no interruptions
2. What does the patient know?
3. How much does the patient want to know? Patients have the right not to know!
...Communicating Bad News

4. Share the information - avoid medical jargon
5. Respond to patient, family feelings
6. Plan follow-up

Adapted from Robert Buckman

When family says "don't tell" ...

- Legal obligation to obtain informed consent from the patient
  Vs.
- Respect for family's wishes

... When family says "don't tell"

- Ask the family:
  - Why not tell?
  - What are you afraid I will say?
  - What are your previous experiences?
  - Is there a personal, cultural, or religious context?
- Talk to the patient together

Addressing Code Status....

- Decision regarding code status should be consistent with goals of care
- Chances of successful resuscitation should be communicated
- Option of full code should not be offered when resuscitation attempts would clearly be futile
When a terminally ill patient insists “everything be done”:

- Patient may fear being abandoned
- Patient/family may not trust physicians
- Patient/family may be hoping for a miracle
- Need to address issues of medical futility – conflict resolution process

Conflict Resolution:

- Conflict regarding patient’s treatment may be between the patient/surrogate and the doctors, it may be between nursing and doctors, or between doctors.

...Conflict Resolution

- All Parties need to be heard
- If any uncertainty, may need to clarify prognosis, treatment options... seek clarification from consultants, second opinions, etc...
- Try to achieve consensus on a time limitation when the outcome is still uncertain (We can all agree that we will continue treatment for another 48 hours, then reassess)

......Conflict Resolution

- If conflict persists, request ethics consultation
- If conflict still persists, offer the patient the option of transferring their care to another physician/hospital.
Withholding, withdrawing treatment
- Decisions should be made based on goals of care
- Withdrawing and withholding treatment is viewed to be the same, ethically and legally
- Must be familiar with your institution's policies

UCSD Policy on Limitation of Life Sustaining Treatment:
- Life sustaining treatment can be withheld/withdrawn when a competent patient/surrogate requests
- Or, when the treatment has no reasonable chance of providing benefit (medically futile)

Common concerns . . .
- Are physicians legally required to "do everything?"
- Is withdrawal or withholding treatment euthanasia?
- Can the treatment of symptoms constitute euthanasia? – concept of "double effect"

Terminal Extubation:
- Once the decision has been made to extubate a patient with the intent of allowing the patient to die, the process should proceed according to protocol, by a physician who is experienced in conducting terminal extubations
Before Extubating:
- Document discussions with patient/family
- DNAR order signed by attending
- Discuss tissue/organ donation
- Remove any unnecessary monitors/alarms
- If possible, move patient to private room

Prepare the family...
- Describe the procedure
- Reassure that comfort is a primary concern and medication is available
- Patient may need to sleep to be comfortable
- Describe uncertainty

Withdrawal protocol—
- Establish adequate symptom control prior to extubation
- Titrate medications
  - Opioids – dosing varies widely. Titrate up rapidly for comfort.
  - Benzodiazepines/sedatives may be added for relief of agitation.
  - MAKE SURE NO PARALYTICS ARE IN EFFECT!

Withdrawal of nutrition, hydration
- Review goals of care – will nutrition/hydration achieve these goals?
- Address misperceptions
- Potential complications from feeding, fluids
- Help family with need to give care
Caring for families:
- Allow them to be with the patient
- Allow them to be helpful
- Keep them informed of changes
- Help them understand what is being done and why
- Assure them of the patient’s comfort

Caring for Staff:
- Direct involvement of senior MD’s/Nurses in caring for the dying pt.
- Effective communication between physicians and nurses re. goals of care
- Ongoing education in end of life care.

...Caring for families:
- Comfort them
- Allow them to express their emotions
- Assure them that their decisions were right
- Help them find meaning in the dying of their loved one
- Assure that they are fed, hydrated, and rested.

...Caring for Staff:
- Administrative Support – providing adequate staffing to care for dying patients who need intensive palliative care.
- Minimize transfer of imminently dying patients out of the ICU.
- Allow opportunities for bereavement and debriefing after a patient dies.
After Patient's Death

- Acknowledge family/loved one's loss and grief – refer to grief support
- Send a note to family
- Consider attending memorial service
- Allow staff time off to attend memorial service

Summary:

- Ethical Decision making – always strive to "do no harm", benefit the patient, and respect patient autonomy
- Always guide treatment decisions according to the Goals of Care
- When cure/prolongation of life no longer achievable, life sustaining treatments should be limited/withdrawn

Summary:

The final goal of care should always be to help patients achieve a peaceful death.
To achieve this, we must not equate death with failure.