Managing Ethical Dilemmas and case studies 2019

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Pre-Test question regarding Objectives

- A When a patient is deemed to be terminally Ill, or in a persistent vegetative state, and the family asks to withdraw from life support, we follow the Process outlined by:
  - 1. Oslerian Ethics
  - 2. KMC policy Regarding establishing DNR status
  - 3. The patients living will
  - 4. MURTIA – The Ohio Modified Uniform Rights of the Terminally Ill Act.

Pre-Test question regarding Objectives

- B The Bioethics Advisory Committee at Grandview/ Southview hospitals :
  - 1. Only meets when needed for really difficult cases
  - 2. will review the chart and tell you what you screwed up and what you have to do to fix it
  - 3. provides real Time clinical ethics Consultation for about 40 cases a year
  - 4. Reviews Corporate compliance issues for the Network.

But First, A Case

A 69 year old patient is admitted in a state of coma with hemodynamic instability. She has a poor prognosis with a potential of brain herniation. The patient does not have a living will and the family has to decide on the code status of the patient. Per the patient's children, the patient would not want to live with assistance from artificial means (i.e. ventilator, feeding tube, etc.). However, the husband wanted to pursue aggressive treatment, giving consent for placement of PEG/Trach

Case

. The decision was a great surprise to the doctors, as it was not recommended by the care team to continue aggressive treatment. The next day, the nursing staff notified the medical care team that the husband Mentioned to a nurse that the reason he wants to continue treatment for his wife is because she was the main bread-winner of the family and he worried that if she passed away, he would not have any money to live/survive. If she is sick, but still alive, he may continue to get some financial assistance from the government.

How would you Proceed? We will come back to this later.....

Nature of Clinical Ethics

- An ethical dilemma is a situation in which two courses of action are available and completely opposite each other, and for which a decision must be made.
- Each opposing course of action is equally urgent, and each choice carries with it the sense that it alone is the right one.
  - Clair Kaplan, NP Ethical Dilemmas. Advanceweb.com
    - 2014

First Steps

- Try to articulate the problem and possible courses of action.
- Rate the urgency of each option
  - Does one argument carry more moral weight?
- Examine your own response
  - What is your bias in a particular case?
- What resources are available to help you solve the dilemma?

Ethical Principles

- Autonomy (respect for people)
- Beneficence (the duty to do good)
- Nonmaleficence (the duty to NOT cause harm)
  - Primum Non Nocere “first do no harm”
- Justice (fair allocation)
- Usually your dilemma will come from competing claims from different parties regarding these principles, and an action which may be “good” for your patient may harm one of their family members

Outcomes

- Utilitarian (do the most good for the most people)
- Outcome analysis that helps define which action does the most good for the most people.
- Sometimes it means looking at how your choice would apply to many cases, not just one individual case.
- Sometimes you have to look beyond this one decision, (such as whether to place a trach and PEG) and follow through how the patient's life will be once they get out of the hospital (will they be in an ECF? Will they be able to recognize their family?)

So if you have a tough case, where can you get help?

- If you have a dilemma, call your Ethics Committee
- Ethics committees often started out at bigger institutions as Dialysis committees, whose task was to decide which patients were to be given dialysis machines in the 1960-s and early 70's.
- After the Medicare Act of 1975 provided coverage for Dialysis, the Dialysis committees were no longer needed. BUT....
- After the 1976 decision of the New Jersey Supreme Court in the Karen Quinlan case, the movement for hospitals to establish Ethics committees had a Judicial guideline to build on, and the Courts DID NOT want to be deciding every time a patient got in serious condition.
- The Infant Doe case from Bloomington Indiana in 1983 lead to regulations by the US Dept of Health and Human Services that hospitals caring for infants establish infant care review committees : that began the modern Ethics Committee evolution.

- The Emergence of Institutional Ethics Committees, Cranford and Doudera, in Institutional Ethics Committees and Health Care Decision Making, Health Admin Press, Ann Arbor, 1984

Bioethics Advisory Committee Functions

- Provides consultations
  - Some committees provide Real time help with cases
    - About 15-20% of committees in the US are structured this way.
- Reviews policies
  - End of Life care
  - Brain Death
  - Withdrawal from life support
- Education of Physicians, Students, Nurses and others.
- Mentoring of the committee members

The Bioethics Advisory Committee at Grandview

- Also serves at Southview, and with outpatient cases.
- Provides Real Time Ethics Consultation service
- Averaging 35-40 cases annually
  - We have reported at National and International Ethics conferences on over 350 cases in over 15 years of clinical Ethics Consultations. (CEC)
- Each consult takes 1-4 hours working through conflicts with families, finding spokesperson, etc, and many are followed for the entire admission.
- Documents the findings and recommendations on the patient's chart in EPIC.

Education on End of Life Care

- Need for healthcare worker and public education is still great, as evidenced by:
- Oregon experience that 10 % of POLST forms are invalid due to improperly completed/ lack of physician signature or date.
- Resuscitation of residents with DNR orders in LTCFs.

Resuscitation of Residents with DNR orders in LTCFs

- Measured the frequency of EMS calls to ECFs for patients with DNR orders
- Calls 392
- DNR 139 (35%)
- Resus. Attempted 29 (21%)
- Becker Yeargen et al. Prehospiital Emergency Care 2003: 7: 303-6.

The Ohio Law on DNR-CC

- Creates a portable DNR
  - **Form** **ID bracelet**
  - **Wallet card**
- Description of Components of CPR
- Stipulates what will NOT be done if pt is DNR
- Provides protection from liability

PSDA passed Nov 1990, in effect Dec 1991.

DNR COMFORT CARE

DNR IDENTIFICATION FORM

☐ **DNRCC**

(If this box is checked the DNR Comfort Care Protocol is activated immediately.)

☐ **DNRCC—Arrest**

(If this box is checked, the DNR Comfort Care Protocol is implemented in the event of a cardiac arrest or a respiratory arrest.)

Patient Name:_____

Address:_____

City_____ State_____ Zip_____

Birthdate_____ Gender ☐ M ☐ F

Signature_____ (optional)

Certification of DNR Comfort Care Status (to be completed by the physician)*

(Check only one box)

☐ ***Do-Not-Resuscitate Order***—My signature below constitutes and confirms a formal order to emergency medical services and other health care personnel that the person identified above is to be treated under the State of Ohio DNR Protocol. I affirm that this order is not contrary to reasonable medical standards or, to the best of my knowledge, contrary to the wishes of the person or of another person who is lawfully authorized to make informed medical decisions on the person's behalf. I also affirm that I have documented the grounds for this order in the person's medical record.

☐ **Living Will (Declaration) and Qualifying Condition**—The person identified above has a valid Ohio Living will (declaration) and has been certified by two physicians in accordance with Ohio law as being terminal or in a permanent unconscious state, or both.

Printed name of physician*:_____

Signature_____ Date_____

Address:_____ Phone_____

City/State_____ Zip_____

* A DNR order may be issued by a certified nurse practitioner or clinical nurse specialist when authorized by section 2133.211 of the Ohio Revised Code.

Ohio Law on DNR-CC

- Living will applies to persistent vegetative state.
- New versions of the Living Will since 1999 have provision for establishing DNR arrest or DNR Comfort Care only.
- DNR-CC-A
- DNR-CC

Definitions

- DNR
  - Old terminology, means Do not Resuscitate.
- DNR-CC-Arrest
  - New Terminology, means do not resuscitate: Provide comfort care when the end comes, continue all other treatment until then.
  - This gets recorded immediately, but the comfort care provisions don't go into effect until the the heart stops etc.

Definitions

- Old terminology : CMO (comfort measures only)
- DNR – CC
  - New terminology
  - Means Comfort Care measures only are to be given, and generally is instituted immediately/ do not wait till the heart stops etc.
  - Discuss with pt/family as to whether any ongoing measures could be STOPPED, such as dialysis, Lab draws, pressors, antibiotics, etc.
  - Withdrawal from life support is a separate matter with its own rules/ requirements

Level of Care Orders

- Procedure for placing limits on resuscitative efforts in institutions (hospitals and ECF's etc)
- Progress note
- Orders
- Copy of Ohio DNR – CC form
- End of each daily PN should state
  - "**Pt is DNR** " or
  - "Pt is Jehovah's Witness" or other limitations.
- Add notice to patients PMHx and Problem list

GRANDVIEW
Hospital & Medical Center
Dayton, OH

SOUTHVIEW
Hospital & Family Health Center
Dayton , OH

ORDERED DATE	TIME	LEVEL OF CARE ORDERS	DISCONTINUED DATE	TIME
		Patient Diagnosis		
		The following are orders established for the medical care of this patient by Dr. _____ after consultation and in accordance with the wishes of the patient and/or surrogate _____.		

		Resuscitative Orders	Yes	No	Not Applicable		
		Mask to Mouth Resuscitation Without Intubation					
		External Chest Compression					
		Electrical Ventricular Defibrillation					
		Chemical Ventricular Defibillation					
		Intubation Without Mechanical Ventilation					
		Intubation With Mechanical Ventilation					
		Electrical Cardioversion for Atrial Tachyarrhythmia					
		Chemical Cardioversion For Atrial Tachyarrhythmia					

If any of the above items are checked yes (x), a Dr. Heart should be called for the intervention(s) specified above
If all the above items are checked no (x), the patient is considered to be DNR (Do Not Resuscitate) identified by Ohio law.
If a patient is admitted with a DNR identification (a "DNR Comfort Care" patient), all of the items above should be checked no (x).

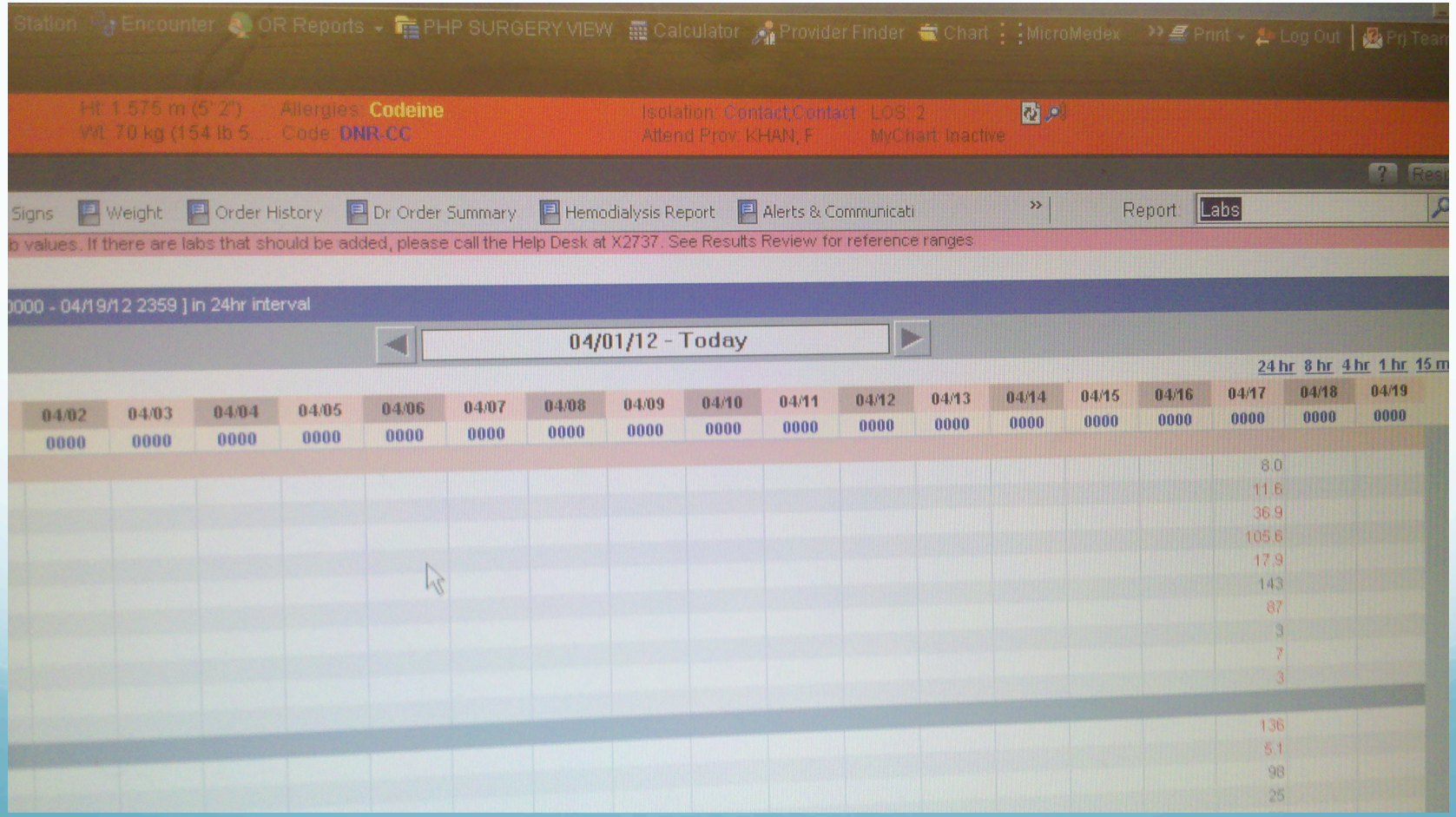
		Supportive Care Orders	Yes	No	Not Applicable		
		Transfer to ICU					
		IV Support					
		IV Hyperalimentation					
		Enternal Nutrition					
		Antiobiotics					
		Chemotherapy					
		Radiation Therapy					
		Radiologic Studies					
		Laboratory Studies					
		Inotropic & Vasoactive Support					
		Palliative Care	**Yes**	**No**	**Not Applicable**		
		Pain Medication					
		Oxygen Therapy					

_____
Physician Signature

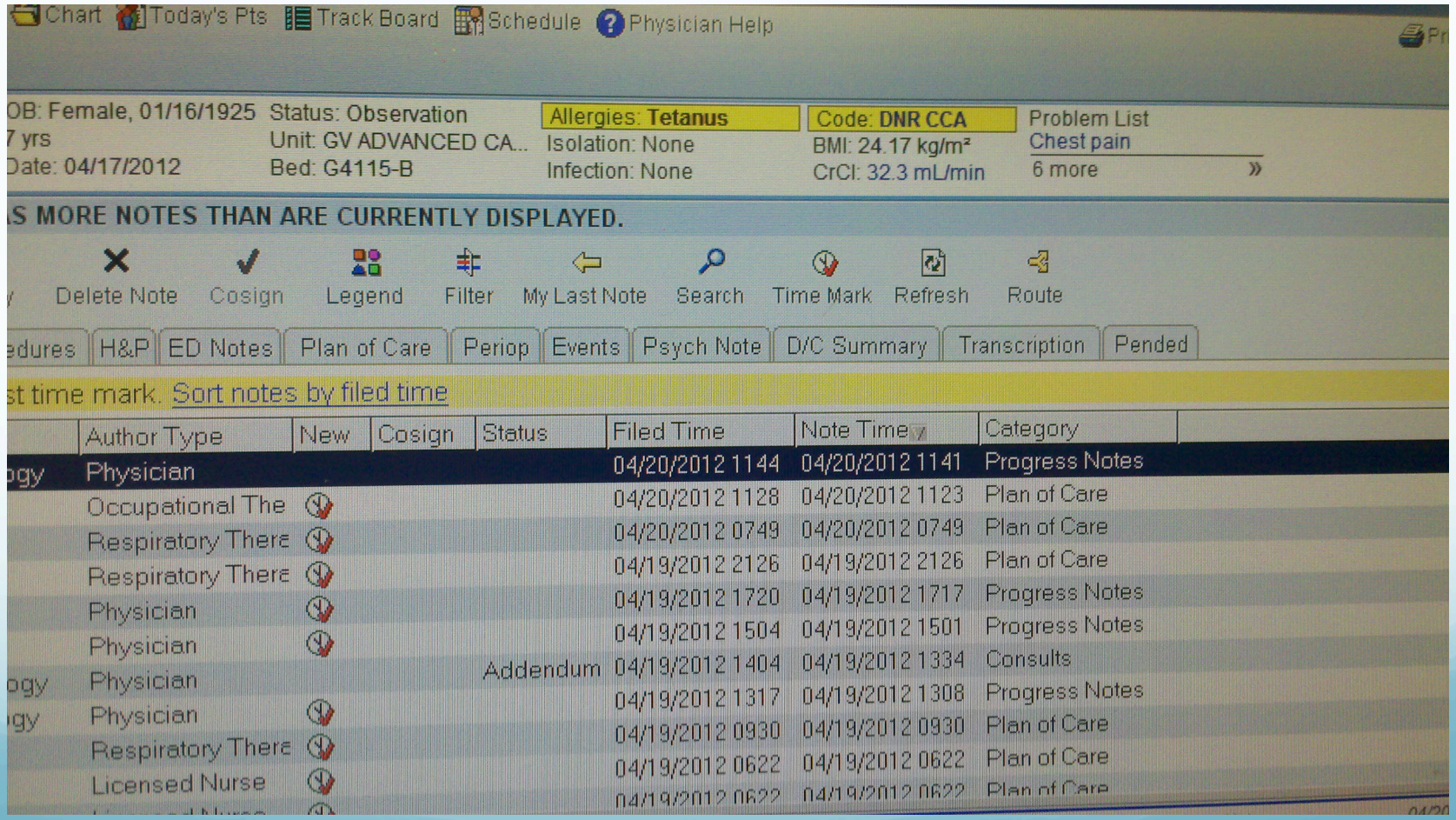
PHYSICIAN'S ORDERS

DS-921 5/99 WHITE- CHART YELLOW-PHARMACY PINK- PHYSICIAN

Identification of Patient wishes to be DNR in EPIC Premier Hospital Network

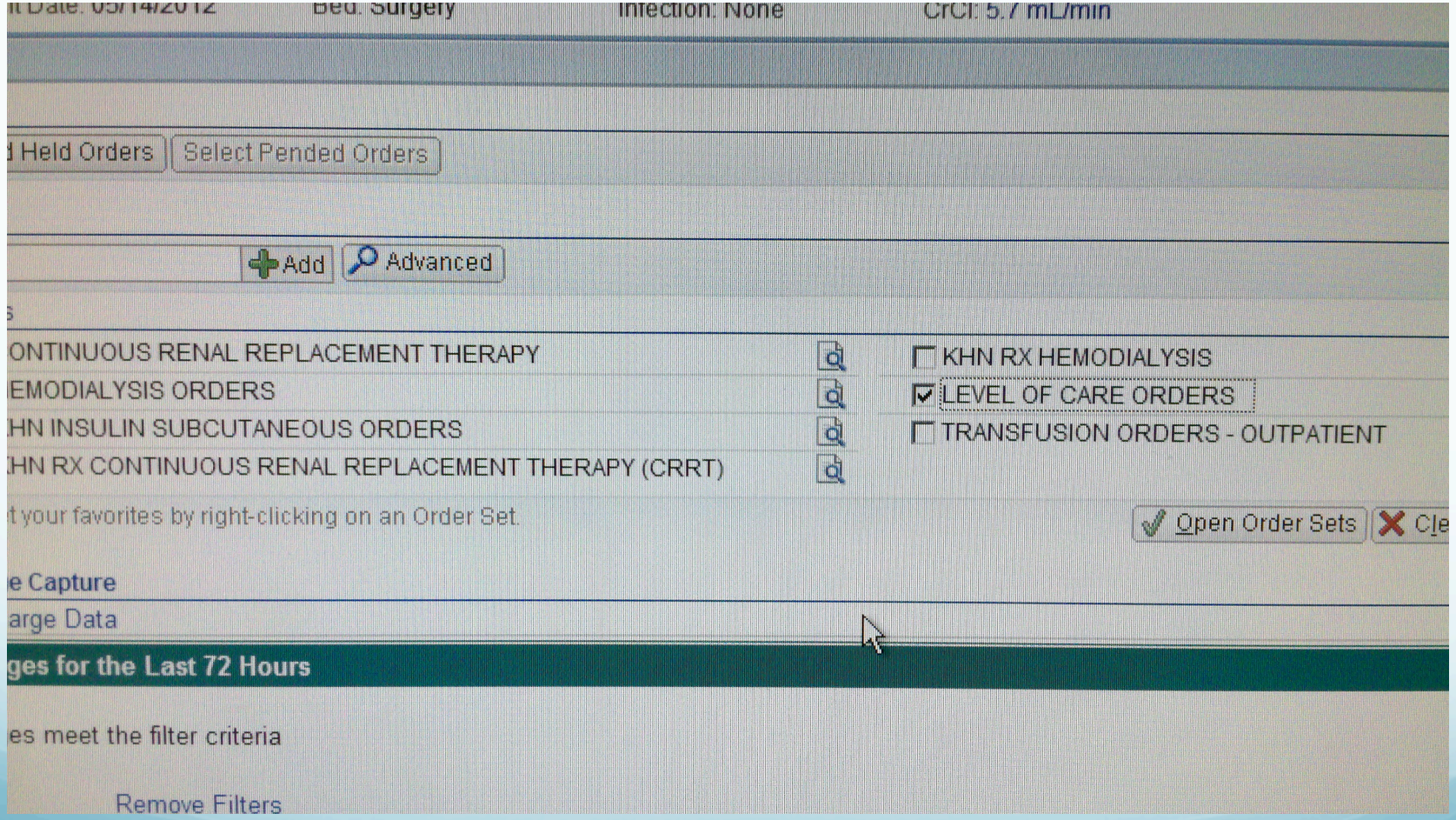


Identification of Patient wishes to be DNR in EPIC Kettering Health Network



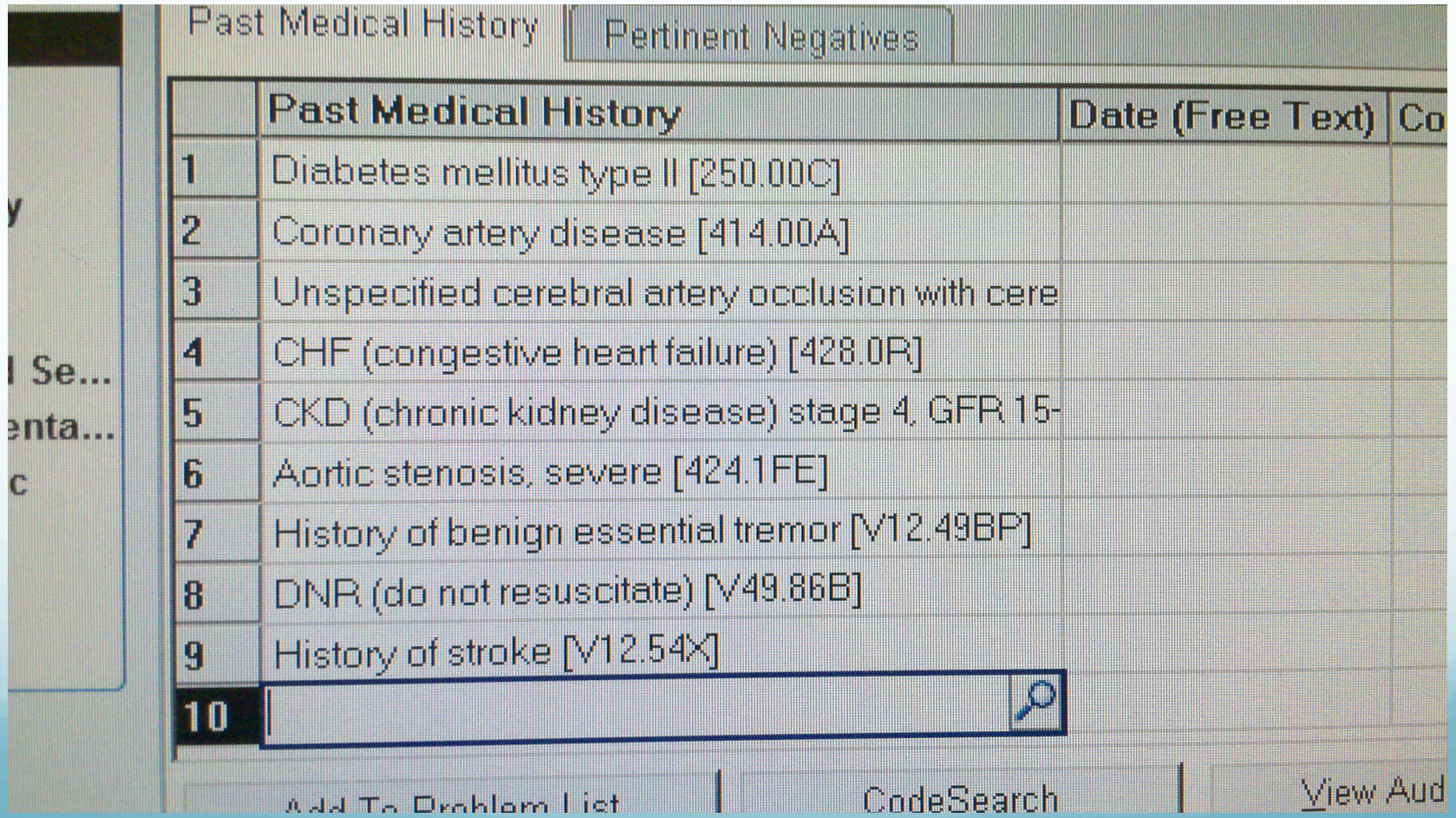
Process for establishing DNR in EPIC

Order Set or enter DNR or “level of care” in new order section.



Process for establishing DNR status in EPIC

Importance of adding the DNR status to the Problem list and PMHx



How I approach the patient

- Intro: one last thing We are supposed to talk about, with anyone who is sick enough to be admitted to the hospital, is whether you have a Living will or DPOA-HC. I am not expecting any problems, but its best to talk about it when there isn't an emergency and you can tell me what you want or don't want.
- So, do you have a living will or Durable Power of Attorney? (DPOA-HC)

How I approach the patient

- Discussion: if the patient has a LW or DPOA-HC, they will usually let you know, and will be open to further discussion and frequently will want DNR. If they don't have any paperwork, I still go on to the next step:

How I approach the patient

- Action Phase: “the piece of paper is not that important. What is more important is have you discussed your wishes with your family? Like I said, I am not expecting any problems, but if your heart stopped beating or you stopped breathing, would you want Chest compressions and electric shocks and having the tube put in so a machine can breath for you?

How I approach the patient

- Action Phase: This usually reveals the patients wishes, or reveals that they haven't thought or talked about it with their family.
- I have never had a family or patient react negatively when the discussion was raised this way.
- Often, the patients who haven't talked with the family will have a discussion later, and the next time I bring it up they will have a decision.

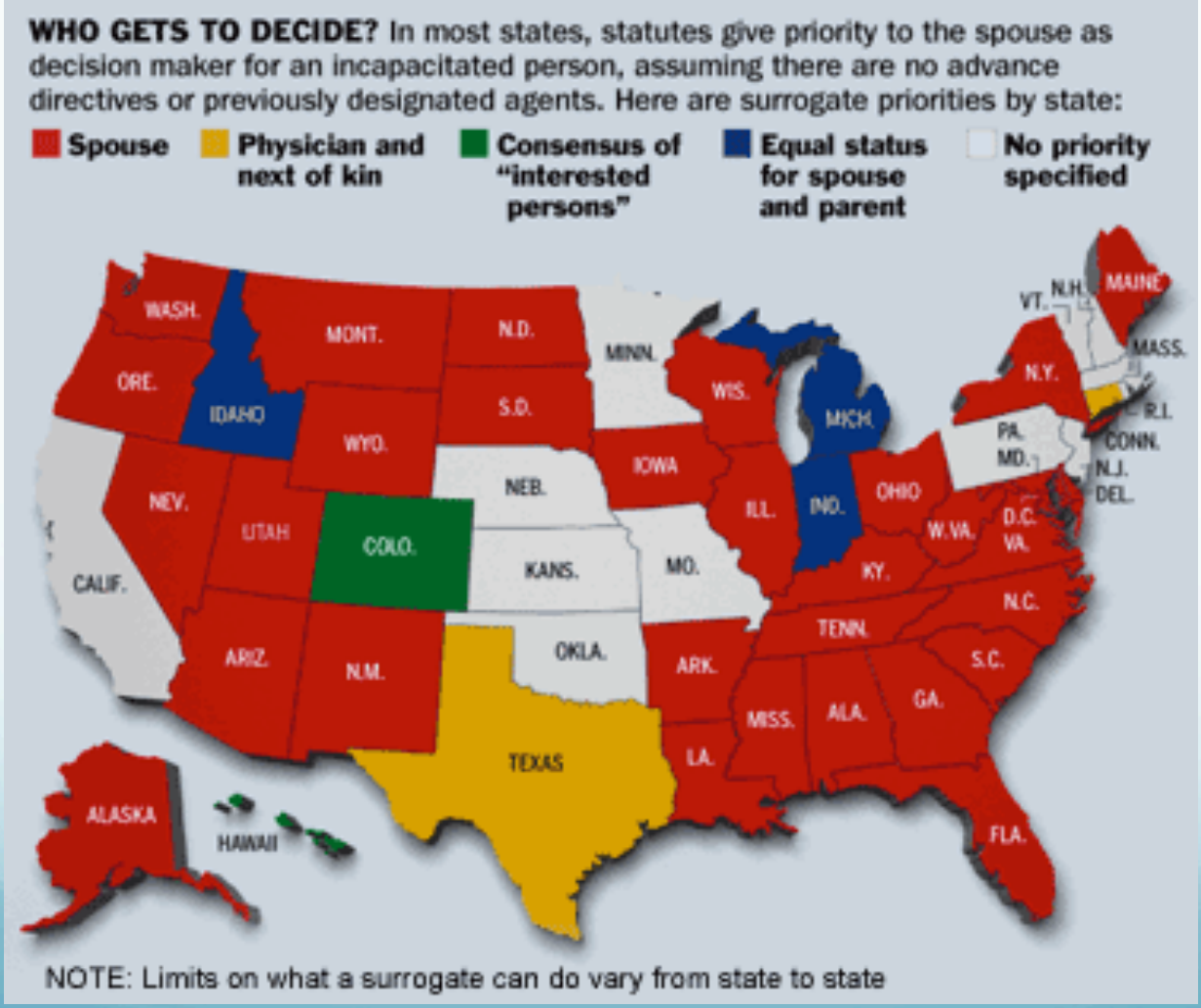
Order of Principles

- Who Decides what care a patient receives?
- Patient's wishes
  - Patient's spokesperson
  - Caregiver
- 2 Physicians on case may invoke Medical necessity or futility
- Ethics committee or consultant

Who Decides?

- By law and by convention / tradition, the spouse is spokesperson, unless there is a compelling reason to suspect they do not have best interest of pt at heart.
- Adult Children are next in line.
- Parents are next

Order of Priority by State



Back to the Case

A 69 year old patient in a state of coma with hemodynamic instability has a poor prognosis with a potential of brain herniation. The patient does not have a living will and the family has to decide on the code status of the patient. Per the patient's children, the patient would not want to live with assistance from artifiical means (i.e. ventilator, feeding tube, etc.). However, the husband wanted to pursue aggressive treatment, giving consent for placement of PEG/Trach

the husband secretly told a nurse that the reason he wants to continue treatment for his wife is because she was the main bread-winner of the family and that if she passed away, he would not have any money to live/survive

Back to the Case

- You have to maintain your relationship with the family, but need help evaluating the appropriateness of the decision by the husband.
- Is the husband the proper spokesperson?
- How would you go about changing his mind if you didn't agree with the rationale he is giving for the decision he is making?

Back to the Case

- In a similar case, I discussed with the family to think about what their mother would want, not what they want. Affirm that it is hard to let their loved one go, but that is the right thing to do. Then we gave them time to think it over, and ultimately did not do the trach/PEG.
- One case we were able to get the patient's longtime physician to come in, and when he said "she told me she'd put a hex on me if I ever put her on machines", they heard her voice, and immediately turned to comfort care only.
- One case we called the sons, who were picking up the father, and they were able to change his mind by the time they arrived at the hospital.

From the Files of the Bioethics Advisory Comm.

- 63 yo male with ALS admitted from home with pneumonia and resp failure. At home, he was using CPAP at night and tube ventilator during the day. Required intubation and vent in the hospital. Was not waking up and Internal Med recommended trach. Wife initially consented to trach, BUT..
- Pt has Living will that explicitly states he does not want trach. Hospital Lawyer contacted by email and stated wife would have to take case to court if she wanted a trach. Family does not really want trach, but felt like they were pressured into the decision. Instead they ask for withdrawal from life support.
- Ethics committee met with patient's wife and discussed with Hospital Attorney, and approved withdrawal from life support, no trach.

From the Files of the Bioethics Advisory Comm.

- 79 yo male with wife of 55 years but separated for 40 years, although they shared the same house. Also has 30 year relationship with SO Saundra, and 10-15 year relationship with a friend named Fallen. Minimal contact with son in Michigan, and brother in Jamestown OH. He is admitted with dementia, pneumonia, unable to care for himself. ECF recommended.
- Son and brother expressed concern about patient being taken advantage of by the wife/ SO's.
- Legally the Decision maker is wife, or Saundra IF she is accepted by the others. They all agree he would NOT want to go to nursing home. Ultimately everyone agreed the wife would take him home .

From the Files of the Bioethics Advisory Comm.

- 21 year old male admitted for cardiac arrest of unconfirmed etiology. Patient's mother is deceased; father is decision maker. Circumstances surrounding the hours leading up to patient's event are being questioned by Vandalia Police Department. Information gathered by Detective of the Vandalia PD suggested that father was aware that patient had injected heroin and lied about this fact to the police and healthcare workers. Information also suggested that patient had been down for much longer than father had originally reported. Vandalia PD suggested that father not be allowed to make healthcare decisions given that he will likely receive criminal charges following patient's death. Patient's sister was willing to accept this role. Father was willing to allow patient's sister to make healthcare decisions. Decision was made to initiate terminal wean on 3/22 at 0930. Terminal wean completed at 0930 on 3/24, in accordance with the Ohio Law on Modified Uniform Rights of the Terminally Ill (MURTIA) - 48 hour rule.

- However, he did not die. Note all drug screens on the patient have been negative. Patient is in a persistent vegetative state with some brain stem activity

From the Files of the Bioethics Advisory Comm.

- 66 yo male with MRDD in long term Group home care. No Guardian and has been providing his own consent. He was admitted with SOB and found to have severe valvular heart disease. Nursing staff in the ICU raised questions about his decision making capacity.
- CEC service discussed case with the group home administrator and staff, who are Forbidden by law from serving as DPOA-HC. Recommendations include :
- OK to proceed with valve replacement surgery, and begin process for long term guardianship. Dr Kaufhold followed the patient in the perioperative period for other issues requiring consent, and he did well.

From the Files of the Bioethics Advisory Comm.

- Part 1 : 94 yo female admitted for mental status change from home. When her family was not around, she immediately awoke and claimed she had to pretend to be comatose to escape. Claims that she is neglected and her niece is trying to kill her. She is blind and HOH. Bed bound.
- She claimed her Niece and Niece's Husband had cared for her sister and took all her money, then she died.
- She also claims she was married to several rich men over the years and has millions in savings/ assets.
- CEC consulted to determine the veracity of patient's claims. Continued.....

From the Files of the Bioethics Advisory Comm.

- Part 2. We spoke with pts lawyer. Pts Niece Shelly is DPOA. Lawyer reports The Niece did take care of pts sister, and she did die. Lawyer confirms patient was married several times and in fact had a large amount of assets. Pt's assets have been systematically transferred to the niece as DPOA for everything including healthcare, since last year.
- Also contacted her Ophthalmologist. He states pt has been declining for years, and has refused ECF until now. States placing pt would be good for the patient and her family both.
- The lawyer and the eye Doc both report patient is “a firecracker” who liked to make things dramatic, and had conflicts with the niece, who they felt was really trying to help her the best she could.
- CEC arranged for Maria Joseph placement, and MJ staff aware pt would like to establish her lawyer as DPOA and DPOA-HC.

So to Summarize

- The Bioethics Advisory Committee at GV/ SV provides real time Medical Ethics consultation.
- We talk to the families and staff about conflicts, and try to find a workable resolution.
- We seek out people who know the patient, who may be willing to tell us how the patient lived, and who may be willing to serve as spokespersons
- We begin the guardianship process for patients who have no one to speak for them
- We Speak for the patients who have no one
- We interact with Guardians, Hospital Lawyers, Law Enforcement, and Adult Protective services to make sure patients are Safe
- We review and apply the policies and laws that govern how we care for patients at critical and controversial points in their health care.

Who to Contact

- Each hospital has an Ethics Committee
- Call Nursing supervisor, risk manager, or Dr Kaufhold
- Ask your Program / specialty Chairperson
- Write an order – at GVH/ SVH you can actually write “Consult Ethics” in EPIC and the request will print up in the Nursing supervisor office. Its still always best to call us to make sure we know.
- Attend a committee meeting to learn more!

Resources

- WWW.POLST.ORG
- Youtube has educational videos for healthcare workers, as well as patient information. (just type POLST in the search)
- Ohio Hospice and Palliative Care organization OHPCO.org
- www.jeffkaufhold.com has ethics lectures and literature