Ethical Challenges Encountered in Palliative Medicine

Christopher M. Blais
Ochsner Medical Center
New Orleans, LA

Disclosure Slide

I have any financial or organizational conflicts of interest to disclose.

Outline

- Palliative Care v. Hospice Care
- Ethical Principles
- Autonomy/MDM Capacity/ACP
- Beneficence/Futility
- Non-maleficence/Futility
- Justice/Access to PC

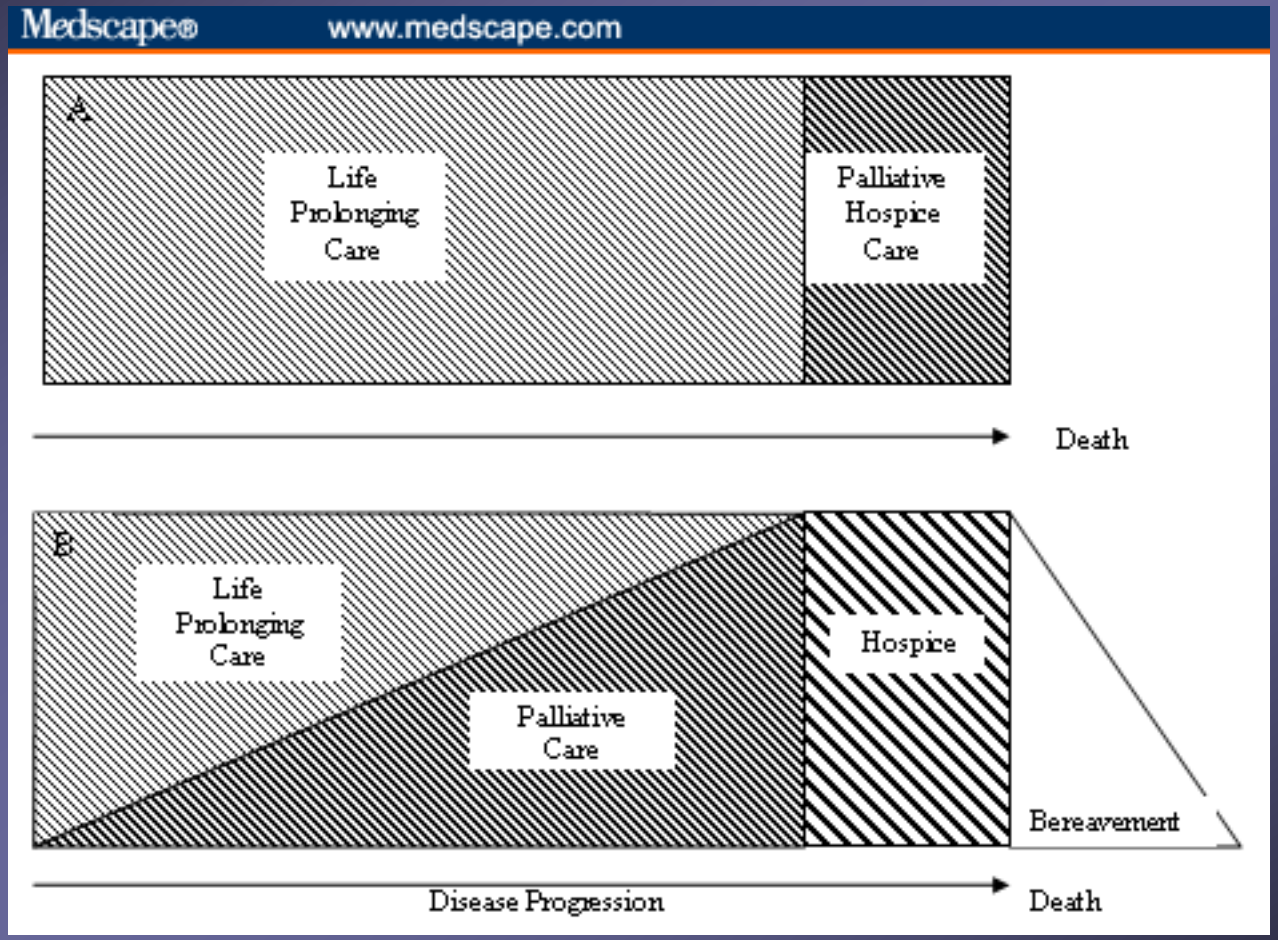
Palliative Care

- Improves quality of life
  - Anticipates, prevents, diagnoses, treats all sources of patient suffering
- Aligns medical treatments with goals of care
- Appropriate at any age or stage of illness
- Can be provided with curative treatments

Hospice Care

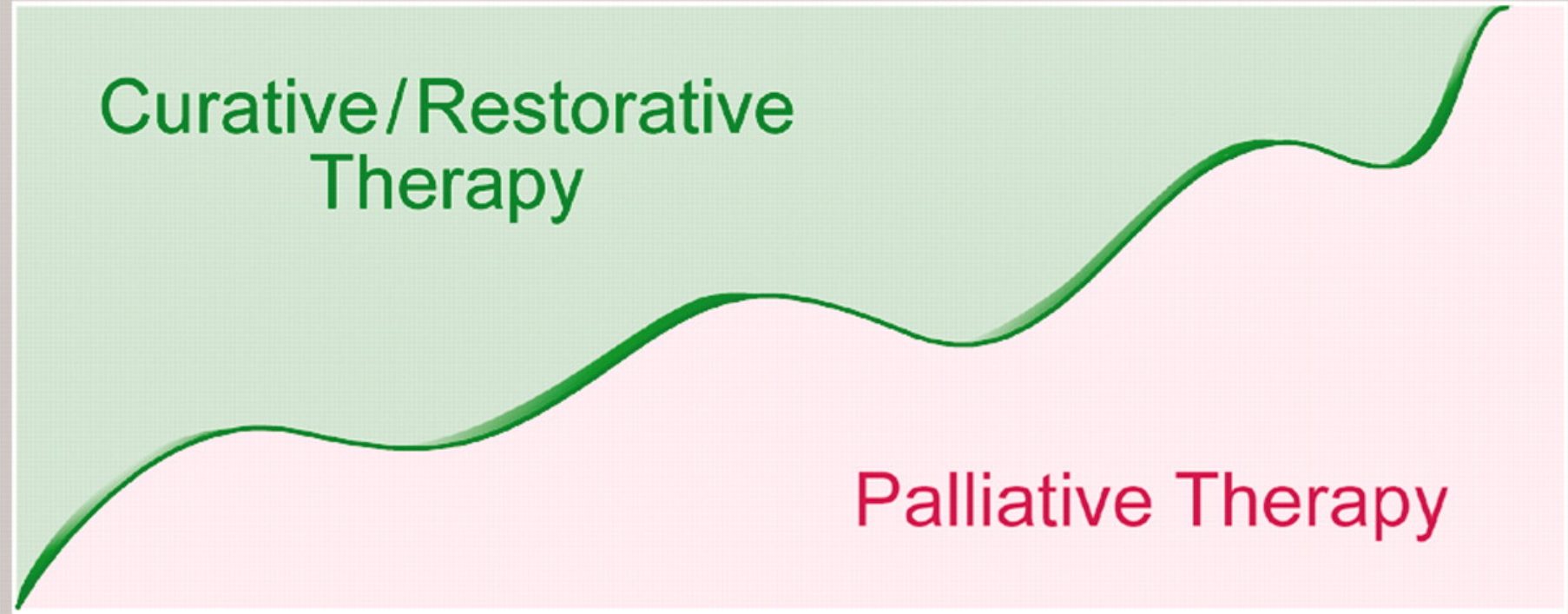
- Palliative care for terminally ill patients with a prognosis of 6 months or less
- Interdisciplinary team
- Improves quality of life
- Focus on comfort
- Bereavement

Continuum of Care



http://www.medscape.com/viewarticle/535720

Continuum of Care - Optimal



Presentation/ Diagnosis | **Illness** | **Death**

Acute | ***Chronic*** | ***Life Threatening***

Adapted from Frank D. Ferris, 2000

Published in *Journal of Palliative Medicine*. October 2011, 14(10): 1091-1093.
DOI: 10.1089/jpm.2011.9645

Mary Ann Liebert, Inc. publishers
www.liebertpub.com

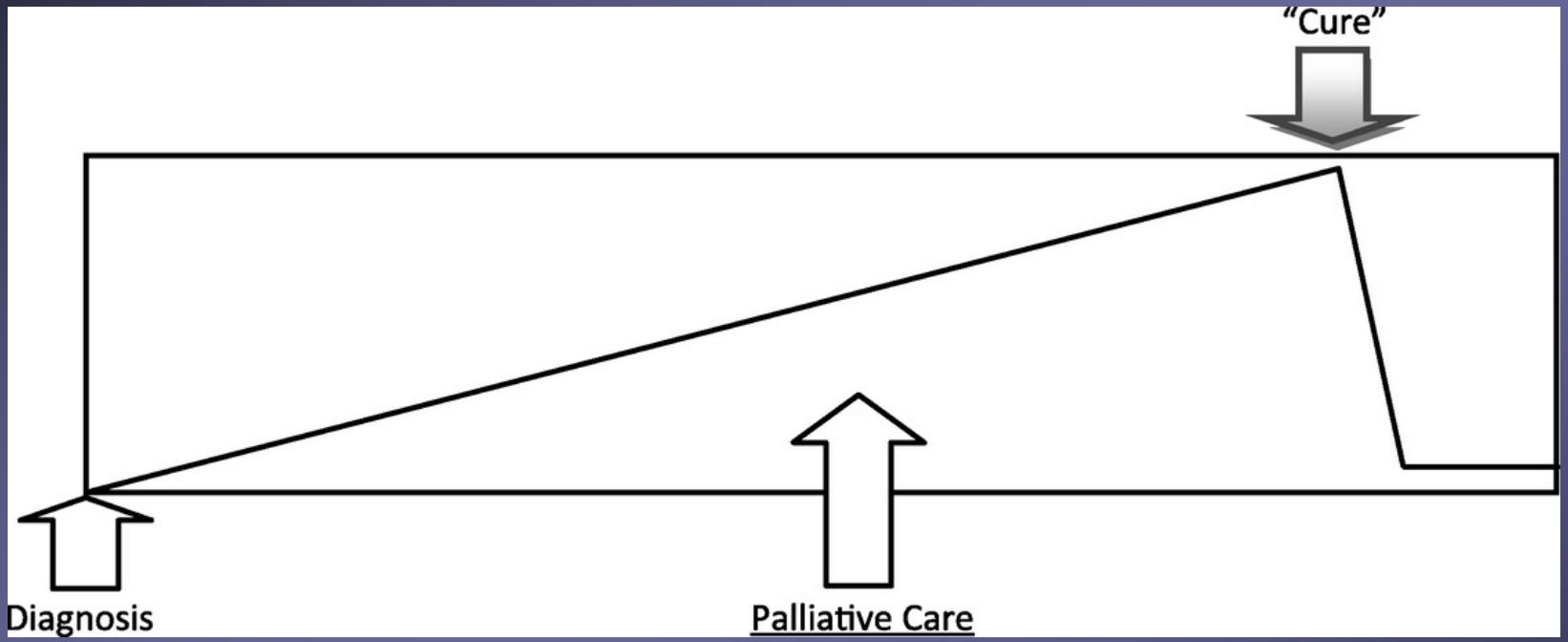
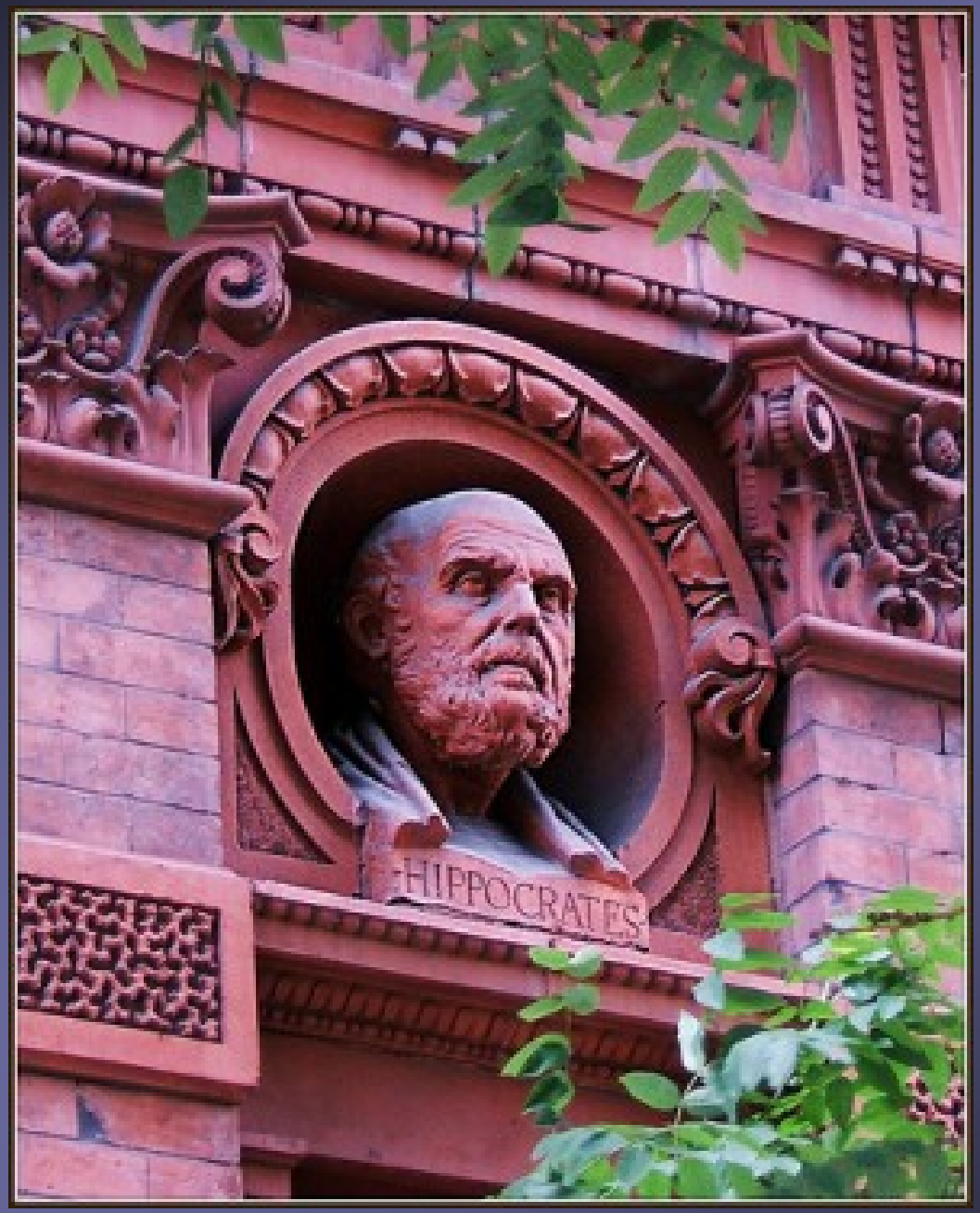


FIG. 3. Comfort and cure model in transplant patients (e.g., heart and kidney).

Parag Bharadwaj, Arvind Shinde, Michael Lill, and Ernst R. Schwarz. Journal of Palliative Medicine. October 2011, 14(10): 1091-1093. doi:10.1089/jpm.2011.9645

Frontline (2011)

http://www.youtube.com/watch?v=Aesmu6MDL_k


HIPPOCRATES

What are medical ethics?

- Hippocratic Oath
- The Principles of Medical Ethics

What are medical ethics?

- Hippocratic Oath
- The Principles of Medical Ethics

The Hippocratic Oath

I swear by Apollo, the healer, Asclepius, Hygieia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment, the following Oath and agreement:

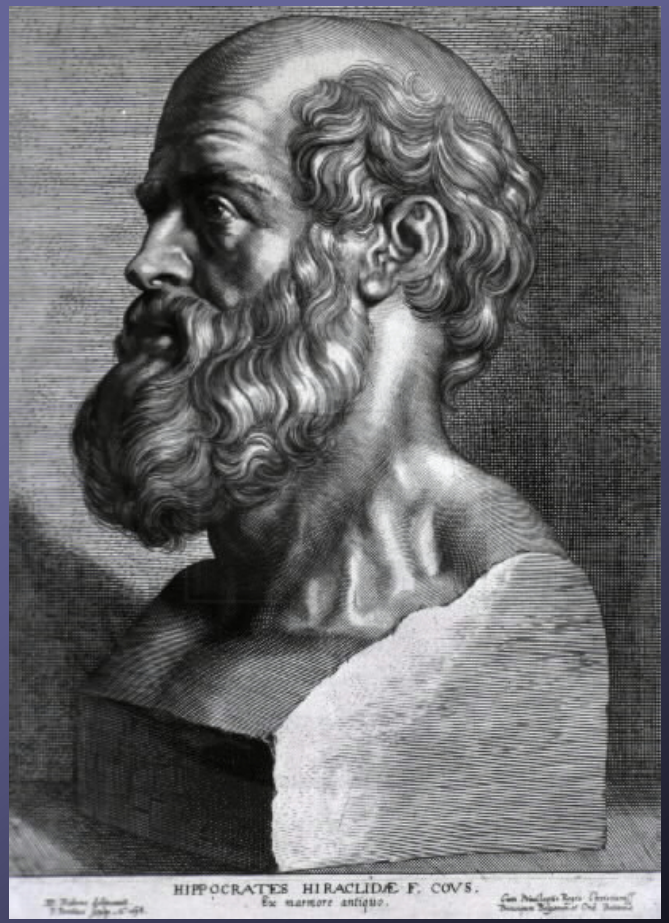
- [Respect teachers as well as future students]
- I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.
- [Will not commit euthanasia or abortion]
- I will preserve the purity of my life and my arts.
- [No surgery for nephrolithiasis]
- [Focus on good of patients, and refrain from sexual relations with them]
- [Maintain confidentiality]

What’s missing?

Patient rights (autonomy)

Hippocrates on Autonomy and Paternalism

- Hippocrates
  - "Conceal most things from the patient, while you are attending to him ... turn his attention away from what is being done to him; ... reveal nothing of the patient's future or present condition."



History of Informed Consent

- Modern American medicine
  - AMA Code of Ethics endorsed beneficent deception of patients "with gloomy prognostications" (1847)

Year	"Beneficent Deception"
1903	√
1912	√
1947	√
1957	√
1980	Deleted

What are medical ethics?

- Hippocratic Oath
- The Principles of Medical Ethics

Principles of Medical Ethics

Autonomy - patient has the right to choose or refuse the treatment

Beneficence – act in the best interest of the patient

Non-maleficence - do no harm

Justice - concerns the distribution of health resources equitably

Dignity - the patient and the persons treating the patient have the right to dignity

Truthfulness and honesty - the concept of informed consent and truth telling

Medical Ethics

1. **Principle of AUTONOMY**

   American society has placed great weight on the freedom of choice of the individual. Each patient as a competent adult, who should be given full information to understand the situation and the options, may choose his own course of action.

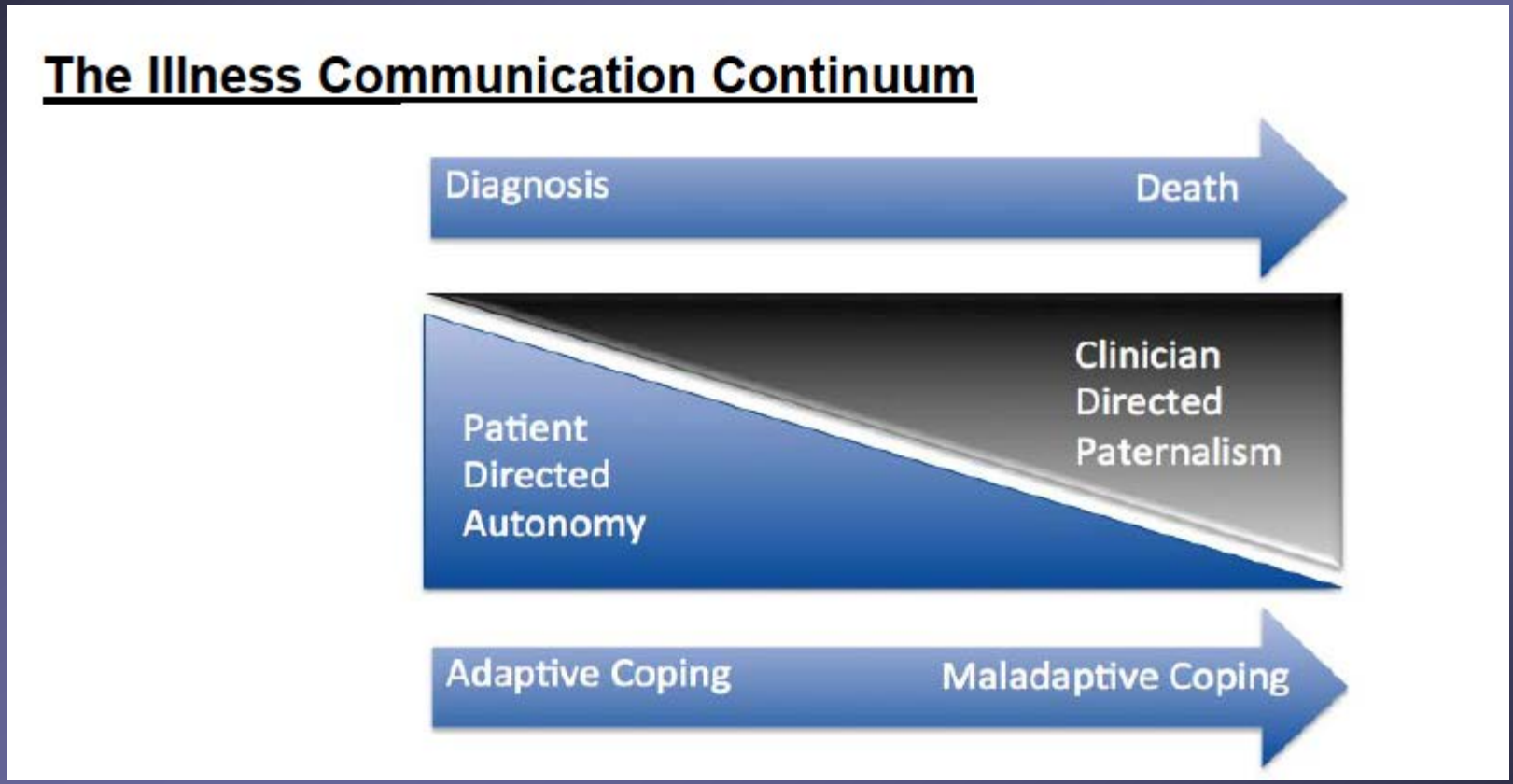
   Does not mean he may choose treatment which is not offered such as demanding surgery for lung cancer when it is not recommended.

People have an abiding desire not to be dead…

"I don't want to achieve immortality through my work. I'd rather achieve it by not dying."

Woody Allen

Beneficent Paternalism



AAHPM Annual Assembly 2013
Redefining The Role of Paternalism in Palliative Medicine
Roeland E, Thornberry K, Mitchell W, Cain J, Onderdonk C

Determining Medical Decision Making Capacity

- Do the history and physical examination confirm that the patient can communicate a choice?
- Can the patient understand the essential elements of informed consent?
- Can the patient assign personal values to the risks and benefits of intervention?
- Is the patient's decision-making capacity stable over time?

CLEVELAND CLINIC JOURNAL OF MEDICINE VOLUME 71 • NUMBER 12 DECEMBER 2004

Medical Ethics

2. Principle of Beneficence

Doctor is expected to act and advocate in the best interest of the patient despite any influences to the contrary. Physician must act to aid acutely injured, strive to cure illness, provide comfort to dying.

Medical Ethics

3. Principle of Non-Maleficence "First do no harm"

Any action to be taken should be free of potential harm to the patient. Physician may recommend treatment which has some risk if the alternative is worse.

Important counter to excesses of beneficence.

Double Effect

- An action that is good in itself that has two effects—an intended and otherwise not reasonably attainable good effect, and an unintended yet foreseen negative effect.

- One need not always abstain from a good action that has foreseeable negative effects.

Medical Ethics

4. Principle of JUSTICE

Synonymous with FAIRNESS

Fair distribution of scarce resources (distributive justice)

JAMA February 27, 2013, Vol 309, No. 8

VIEWPOINT

Why the Ethics of Parsimonious Medicine Is Not the Ethics of Rationing

Jon C. Tilburt, MD

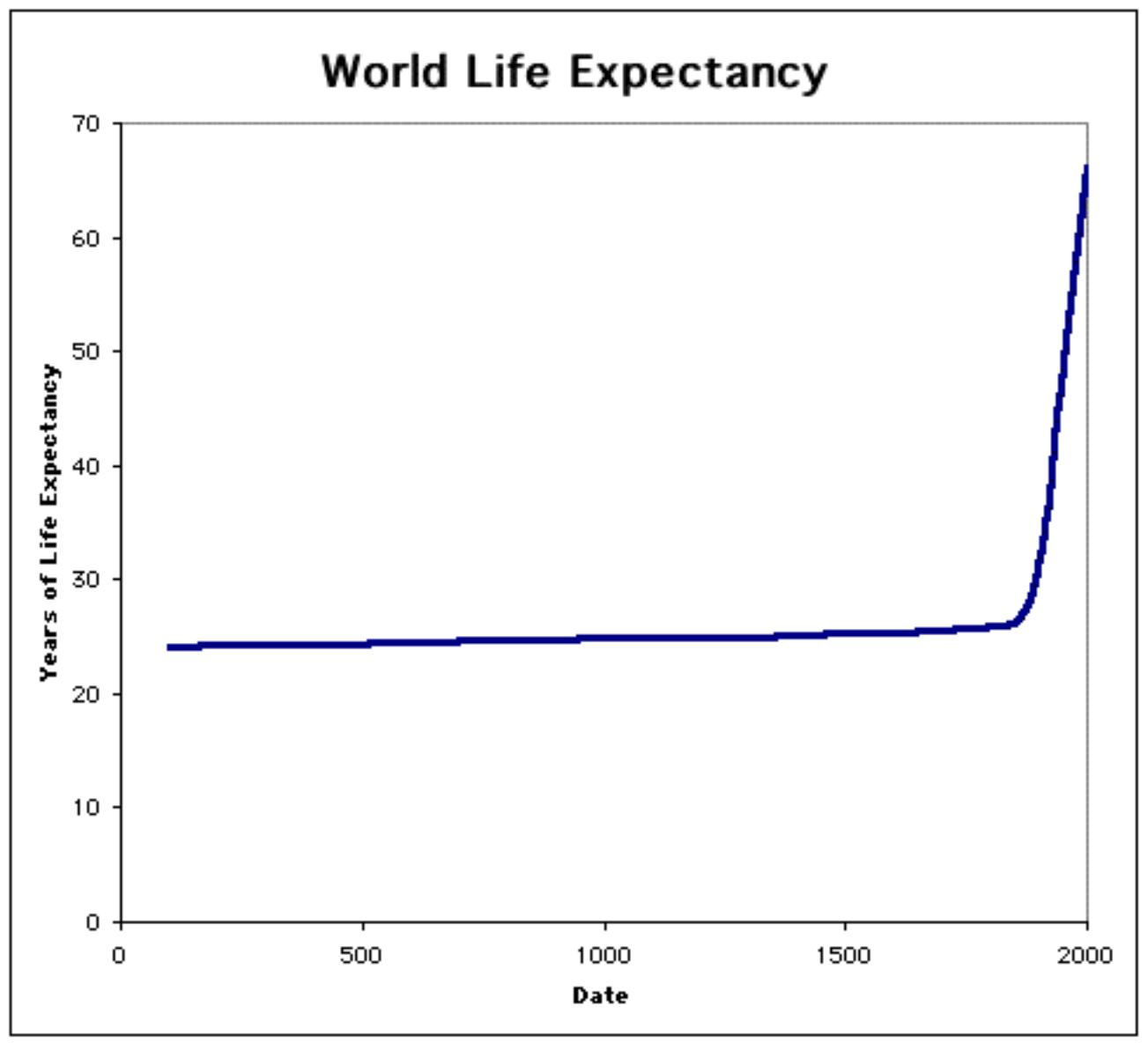
Christine K. Cassel, MD

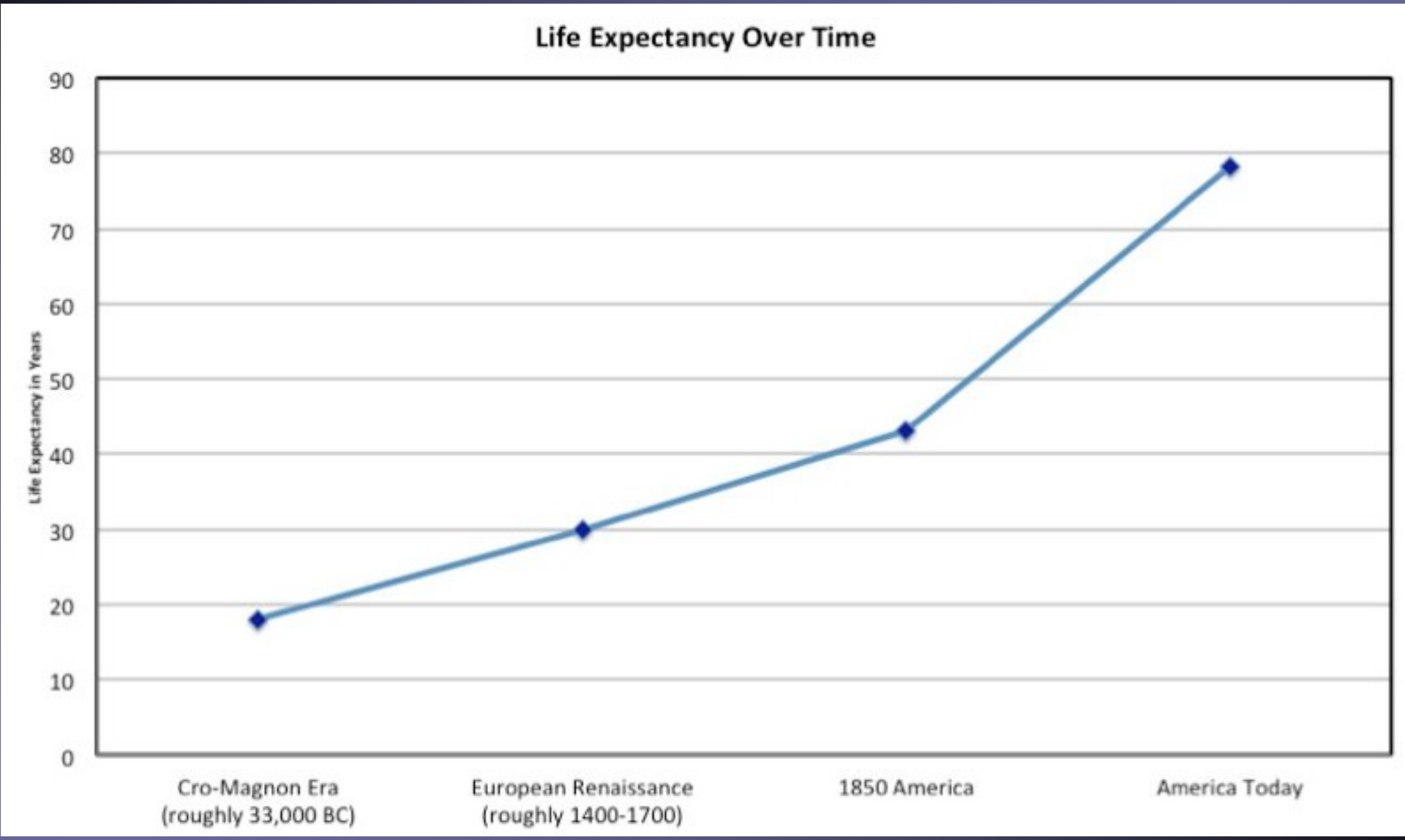
THE ETHICS OF RATIONING HEALTH CARE RESOURCES has been debated for decades. Opponents of rationing are concerned that societal interests will supplant respect for individual patient choice and professional judgment. Advocates argue that injustices in the current system necessitate that physicians use resources prudently on behalf of society, even in their benefit, that guide allocation of truly scarce resources (eg, organs). Thus, different types of rationing may be more or less ethically justified, depending on the underlying ethical rationale.

The ethical rationale for rationing appropriately rests on a concern for distributive justice. Some have argued[5] that basic health status is a prerequisite for equal opportunity to participate in society and that health care is therefore a basic social good or even a human right. To the extent that health care helps citizens obtain health, health care should be distributed fairly throughout society, especially where

“Parsimonious care that utilizes the most efficient means to effectively diagnose a condition and treat a patient respects the need to use resources wisely and to help ensure that resources are equitably available.”

Access to Palliative Care: The Calm Before the Storm


World Life Expectancy
Years of Life Expectancy
70
60
50
40
30
20
10
0
0
500
1000
1500
2000
Date


Life Expectancy Over Time
Life Expectancy in Years
90
80
70
60
50
40
30
20
10
0
Cro-Magnon Era
(roughly 33,000 BC)
European Renaissance
(roughly 1400-1700)
1850 America
America Today

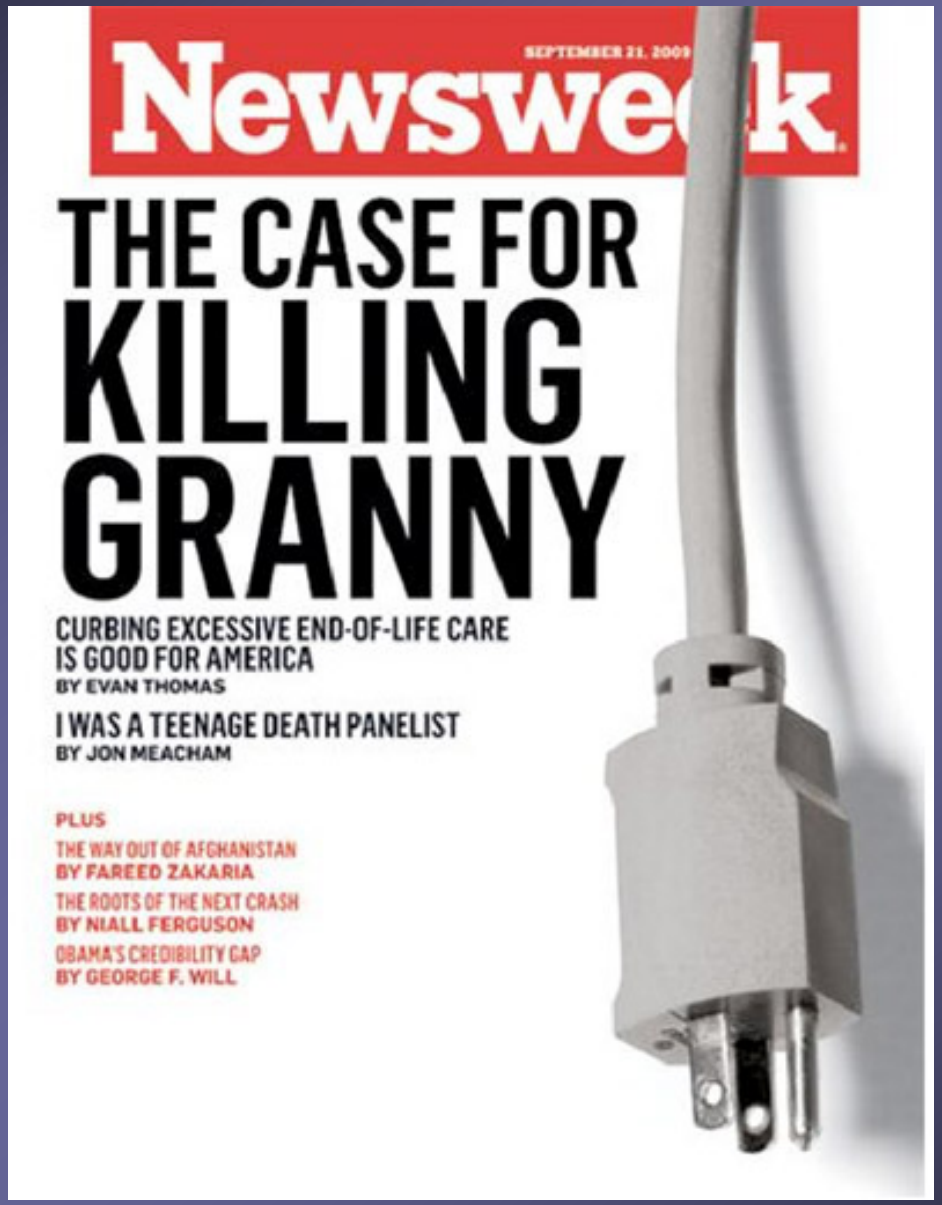
Life Expectancy in 2010

- Median age of death is 78 years
- Among survivors to age 65, age at death is 82 years
- Among survivors to age 80, age at death is 88 years
- The number of people over age 85 will double to 9 million by the year 2030 (CDC)

Care for the Seriously Ill

- Unprecedented gains in life expectancy since the turn of the century
- Cause of death has shifted from acute sudden illness to chronic disease
- Untreated physical symptoms
- Unmet patient/family needs
- Disparities in access to care

Barriers to PC Access


Newsweek
SEPTEMBER 21, 2009
THE CASE FOR KILLING GRANNY
CURBING EXCESSIVE END-OF-LIFE CARE IS GOOD FOR AMERICA
BY EVAN THOMAS
I WAS A TEENAGE DEATH PANELIST
BY JON MEACHAM
PLUS
THE WAY OUT OF AFGHANISTAN
BY FAREED ZAKARIA
THE ROOTS OF THE NEXT CRASH
BY NIALL FERGUSON
OBAMA'S CREDIBILITY GAP
BY GEORGE F. WILL

Palliative Care linked to EOL

- Linked to “end of life” care in the minds of the public, policy makers, and many in the medical profession

- Major barrier to ensuring access to high quality care for people with serious and advanced illness

Common Ethical Questions

- What counts as a “benefit” for critically ill patients?
- What constitutes as “harm” for critically ill patients?
- Who is best situated to make decisions for patients who are unable to make decisions for themselves?
- What criteria should be used in making these life and death decisions?
- To what degree should societal factors influence or constrain individual patient choices?

Non-beneficial Care

Differential diagnosis of futility situations

- More time required for acceptance
- Inappropriate surrogate
- Misunderstanding/failure to communicate
- Personal factors
- Values conflict

An ethical dilemma

"An ethical dilemma involves a conflict of values, where there is more than one acceptable course of action or, more often, there are mutually exclusive goods, thus forcing the clinician to choose among them." (Thomasma 1978)

Other contributing causes to futility issues?

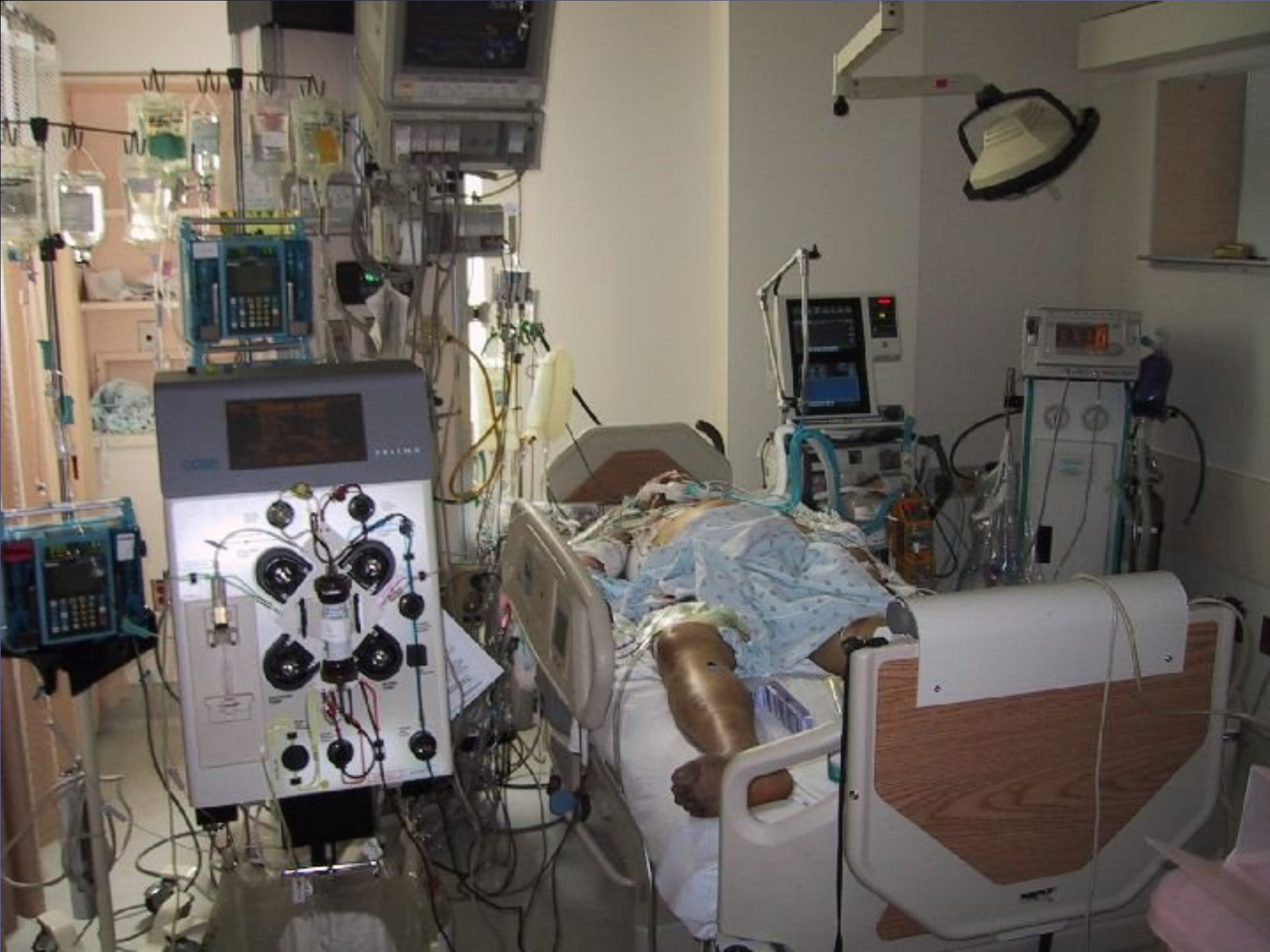
- The health care system and/ or Society
  - Too many doctors involved
  - Excessive or conflicting information
  - No leadership/no recommendations
  - Unrealistic expectations

Case Presentation

- 72 y/o woman with severe aortic stenosis.
- Experiencing SOB with minimal exertion
- She was offered an AVR as a high risk candidate
- She was willing to accept the risk of death because she was so miserable

Case Presentation

- She suffered a CVA intra-operatively
- Daughter wanted to continue life-sustaining therapies
- PEG, tracheostomy, hemodialysis, LTAC followed



Case Presentation

- Died 4 weeks later in LTAC after dialysis was discontinued
- Disregard principles of medical ethics?
- ACP?

Advanced Care Plans

- HCPOA
- Advanced Directives/Living Will
- LaPOST

OCHSNER CLINIC FOUNDATION
ADVANCED DIRECTIVES
LIVING WILL

WITHHOLDING OR WITHDRAWAL OF
LIFE-SUSTAINING MEDICAL PROCEDURES
(LA.REV.STAT.40:1299.58.3)

The Kind Of Medical Treatment I Want Or Do Not Want

I, _____, believe that my life is precious and I deserve to be treated with dignity. If the time comes that I am very sick and am not able to speak for myself, I would like for my wishes to be respected and followed. The instructions that I am including in this section are to let my family, my doctors and other health care providers, my friends and all others know the kind of medical treatment that I want or do not want.

If at any time I should have an incurable injury, disease, or illness, or be in a continual, profound comatose state with no reasonable chance of recovery, certified to be in a terminal and irreversible condition by two physicians who have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to prolong artificially the dying process, I would like the following instructions to be followed:

Close To Death: If my doctor and another physician both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death OR

In A Coma and Not Expected To Wake Up or Recover: If my doctor and another physician both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death OR

Permanent And Severe Brain Damage And Not Expected To Recover: If my doctor and another physician both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support would only delay the moment of my death (Choose *one* of the following):

I

I want to have life-support treatment. (Life-support means any medical procedure, device or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and wa r supplied artificially by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; and antibiotics. (Cross out anything in the definition that you do not agree with

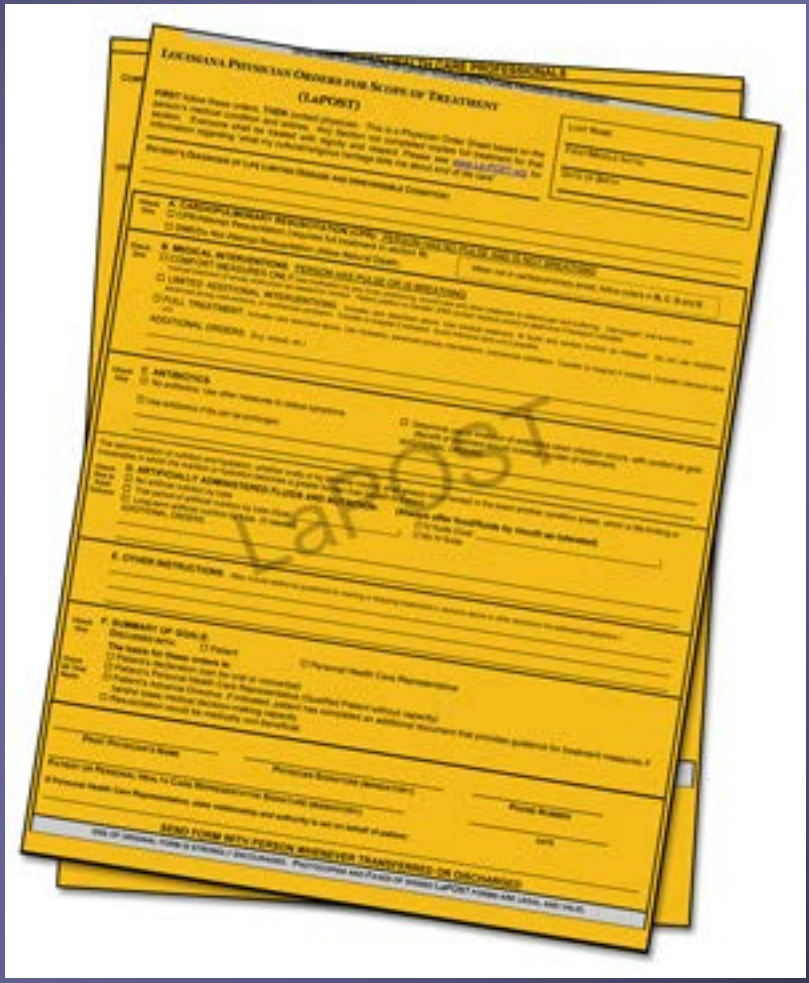
I

I do not want life-support treatment. If it has been started, I want it stopped.

I

I want to have life-support treatment if my doctor believes it could help, but I want my doctor to stop giving me life-support treatment if it is not helping conditions or symptoms.

Louisiana Physician Orders for Scope of Treatment



www.la-post.org

LOUISIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT

(LaPOST)

FIRST follow these orders, **THEN** contact physician. This is a Physician Order Sheet based on the person's medical condition and wishes. Any Section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect. Please see www.La-POST.org for information regarding "what my cultural/religious heritage tells me about end of life care"

LAST NAME

FIRST/MIDDLE INITIAL

DATE OF BIRTH

PATIENT'S DIAGNOSIS OF LIFE LIMITING DISEASE AND IRREVERSIBLE CONDITION:

Check One

A. CARDIOPULMONARY RESUSCITATION (CPR): PERSON HAS NO PULSE AND IS NOT BREATHING

☐ CPR/Attempt Resuscitation (requires full treatment in section B)

☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in **B, C, D** and **E.**

Check One

B. MEDICAL INTERVENTIONS: PERSON HAS PULSE OR IS BREATHING

☐ COMFORT MEASURES ONLY Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. *Patient prefers no transfer: EMS contact medical control to determine if transport indicated.*

☐ LIMITED ADDITIONAL INTERVENTIONS: Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubations, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care unit if possible.

☐ FULL TREATMENT: Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation. Transfer to hospital if indicated, Includes intensive care unit.

ADDITIONAL ORDERS: *(e.g. dialysis, etc.)*

Check One

C. ANTIBIOTICS

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Use antibiotics if life can be prolonged.

☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal. (Benefit of treatment should outweigh burden of treatment)

ADDITIONAL ORDERS:

The administration of nutrition and hydration, whether orally or by invasive means, shall always occur except in the event another condition arises, which is life-limiting or irreversible in which the nutrition or hydration becomes a greater burden than benefit to Patient.

Check One in Each Column

D. ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: **(Always offer food/fluids by mouth as tolerated)**

☐ No artificial nutrition by tube.

☐ Trial period of artificial nutrition by tube (Goal : _____)

☐ Long-term artificial nutrition by tube. (If needed)

☐ IV fluids (Goal : _____)

☐ No IV fluids

ADDITIONAL ORDERS:

E. OTHER INSTRUCTIONS: (May include additional guidelines for starting or stopping treatments in sections above or other directions not addressed elsewhere.)

Check One

F. SUMMARY OF GOALS:

DISCUSSED WITH: ☐ Patient ☐ Personal Health Care Representative

Check All That Apply

The basis for these orders is:

☐ Patient's declaration (can be oral or nonverbal)

☐ Patient's Personal Health Care Representative (Qualified Patient without capacity)

☐ Patient's Advance Directive, if indicated, patient has completed an additional document that provides guidance for treatment measures if he/she loses medical decision-making capacity.

☐ Resuscitation would be medically non-beneficial.

PRINT PHYSICIAN'S NAME

PHYSICIAN SIGNATURE (MANDATORY)

PHONE NUMBER

CPR Survival: Hospitalized Cancer Patients

- Meta-analysis of 42 studies
- Overall survival 6.2% (1 in 16)
  - Localized disease 9.5%
  - Metastatic disease 5.6%
  - Hematologic malign. 2.0%
  - Stem cell recipients 0%

  - Reisfield GM et al. Resuscitation 2006

Death after resuscitation attempt

- Immediate death
- Prolonged death
  - 2/3 of people who survive immediate event die within days to weeks in the ICU
  - Often not discussed as an outcome
  - Not the type of death most people hope for
  - Morbidity for patient, family members, and clinicians

    - Pochard F et al. J Crit Care 2005
    - Azoulay E et al. Am J Respir Crit Care Med 2005
    - Embriaco N et al. Curr Opin Crit Care 2007

Final Thoughts

Ethical Challenges in Palliative Medicine

- Complex thorny dilemmas cannot be reduced to simplistic formula answers.
- With many competing values solutions are not always clean and easy
- Respect and Communication are key
- The process can be positive/satisfying to all involved even if the result is not what a particular individual would have chosen.

Critical Care (1997)

What’s missing here?

Case

- 80 yo woman admitted with dementia aspiration pneumonia
- Arrested
- Resuscitated and transferred to ICU
- Arrested again and resuscitated
- Met with family to discuss GOC
- Recommended comfort care and DNR order to allow a natural death if patient died again

Case

- Daughter assented
- 24 hours later the family requested that the DNR order be rescinded
- Physician refused based on principles of beneficence and non-maleficence
- Family insisted anyway, MD still refused.

What would you do?

Case

- Another MD changed the code status
- 24 hours later the family requested that the code status be changed back to DNR

Questions?