Seven-Step Model for Examining Ethical Dilemmas

1. Determine the facts
2. Define the precise ethical issue
3. Identify the major principles, rules, and values
4. Specify the alternatives
5. Compare values and alternatives
6. Assess the consequences
7. Make a decision

ETHICAL CHALLENGES AT THE END OF LIFE

- Assessing decision making capacity
- Withholding vs. withdrawing treatment
- Doctrine of double effect
- Artificial nutrition and hydration
- Futility
- Physician assisted suicide and euthanasia

ASSESSING DECISION MAKING CAPACITY

Competent vs. decisional

The case of the demented patient

Who does it?

"Testing" decision making capacity

Ability to communicate

Ability to understand treatment options

Ability to grasp consequences of accepting or declining therapy

Ability to reason

ASSESSING DECISION MAKING CAPACITY

The case of the depressed patient

Usually decisional but preferences can be clouded by severe depression

Psychiatrist should be involved

Surrogate may need to be involved

Ethics Consultation

Careful with decisions to limit or withdraw or withhold care

Ethnic and cultural variations

WITHHOLDING VS. WITHDRAWING TREATMENT

Morally and legally equivalent

Moral factors are the same including

- Respect of patient autonomy
- Intention of the physician
- Consequences and cause of death

Withdrawing care is much more emotionally difficult

Withdrawing care should be less controversial if it does not produce the desired effect after a specified time

DOCTRINE OF DOUBLE EFFECT

The doctrine applies to interventions that have both a good and a bad effect

The intervention may be used with the intent to achieve the good effect, but with the foreseen consequence of causing the bad effect. This is permissible as long as the intent is clear for the good effect

DOCTRINE OF DOUBLE EFFECT

Are you killing my father with too much Morphine?

Giving a medication such as Morphine with the intention of making the patient comfortable at the end of life, but with the foreseen consequence (perhaps even likelihood) of hastening the patient's death by respiratory depression **is permissible since The intention here is not to kill the patient.**

The clinical priority here is to relieve suffering at the end of life

ARTIFICIAL NUTRITION AND HYDRATION

Medical debate

Evidence supports the view that dehydration in terminally ill patients helps symptoms

- Less cough and chest congestion and pleural effusion
- Decreased urine output and need for catheterization
- Decreased GI fluid and bloating and diarrhea and ascites
- Decreased leg edema and pain
- No thirst (Poor correlation with hydration status in the terminally ill)

Most patients dying in acute care hospital receive hydration until death
Most patients who die in Hospice hospitals or at home receive no fluids

ARTIFICIAL NUTRITION AND HYDRATION

DISCUSS WITH PATIENT AND FAMILY

SOMETIMES APPROACH NEEDS TO BE INDIVIDUALIZED

MEDICAL FUTILITY

88 year old male with history of pancreatic cancer, with metastases to liver and abdominal wall. Patient has end stage renal disease on regular hemodialysis, recurrent respiratory failure. He has now been hospitalized for close to 6 months, mostly in the ICU on mechanical ventilation and sedation and artificial nutrition. Exam shows evidence of tumor invasion of abdominal wall with ulceration. Patient unresponsive and unable to decide for himself.

MEDICAL FUTILITY

Family dysfunctional and divided and manipulative, insisting that all be done and expecting a miracle and healing through faith. Daughters and son are all professionals in administrative jobs, one daughter is a judge her self. They all sate that life is precious and that he is fighting to live. Should stay full code. Lengthy daily discussions of every detail about patient's care and procedures.

Patient's next of kin is a second younger wife who is intimidated and threatened by the powerful children. She is younger than some of the children, and is unable or unwilling to go against their wishes.

MEDICAL FUTILITY

Numerous physicians involved in the case. At times, confusing and contradicting messages are given to the family. Palliative care service involved on different occasions during hospitalization without progress to EOL care.

Nurses distressed about taking care of this debilitated and dying patient with visible terminal cancer, and who appears to be uncomfortable and at times in pain. They are in tears frequently as the family members' demands are often overwhelming and unreasonable.

Ethics consultation requested.

MEDICAL FUTILITY

Futile treatment is any course of treatment that provides no beneficial outcome or is medically ineffective or even harmful to the patient. It is usually contrary to generally accepted standards of care

A treatment may have an effect on the patient but may not benefit the patient

Treating the disease and not treating the patient

Treating the numbers and not treating the patient

MEDICAL FUTILITY

* Quantitative futility

  The likelihood that an intervention will benefit the patient is exceedingly low (less than 1/100)

* Qualitative futility

  The quality of benefit an intervention will produce is exceedingly poor (Goals/Definition of recovery)

MEDICAL FUTILITY

PHYSICIAN AUTONOMY

INTEGRITY OF MEDICAL PROFESSION

VS

PATIENT/SURROGATE AUTONOMY

TYPICALLY A CONFLICT SITUATION

MEDICAL FUTILITY

Physicians have no obligation to offer treatments that do not benefit their patients

Although respect for patient autonomy entitles them to choose a medically acceptable treatment option, it does not not entitle the patients to receive whatever treatments they ask for

Futility determination should conform with professional standards of care

MEDICAL FUTILITY

Discussion of futility with family/surrogate. Identification of goals of treatment. Discuss rationale for withholding or withdrawing medical interventions.

Obtain consensus and an unified position of all consultants and healthcare workers involved with care

Obtain help from third parties, second opinion, psychiatry, and risk management

If no consensus, may resort to patient transfer, independent mediation or probation for court-appointed guardian

PHYSICIAN ASSISTED SUICIDE

Dr Jack Kevorkian performed first PAS on a woman with early Alzheimer's disease in Michigan in 1990. Charges were dropped for no law outlawed suicide or assisting in it

He helped more than 40 people proceed with PAS

He Crossed the line by euthanizing a patient himself and airing the tape on "60 minutes" Convicted of second degree murder and jailed for eight years

While 60% of terminally ill patients support PAS, only 10.6% consider it

PHYSICIAN ASSISTED SUICIDE

Now legal in Oregon, Washington, and Vermont States

The **Oregon Death with Dignity Act** passed 1994 (51.3% of vote)

- Patients with terminal illness (< than 6 month survival)
- Written request by patient
- Two witnesses attest that patient is competent (one not family member)

Law used 77 times in 2012

PHYSICIAN ASSISTED SUICIDE

CONCERNS

- Alternative to adequate care in un/underinsured patients
- Spread of use to patients who are not decisional
- May be chosen by patients to avoid burden on family
- Society ridding itself of the vulnerable and dependent
- Technical problems

EUTHANASIA

Physician intentionally ends a patient's life at the patient's request and with the patient's full informed consent

Illegal in the USA

Legal only in Belgium and The Netherlands