

SAEM ETHICS CURRICULUM

Module 3: End of Life Issues

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3.1 Honoring Patient Preferences: Advance Directives and Do Not Attempt Resuscitation (DNR) Orders

3.2 Futility

3.3 Withdrawing and withholding treatments

3.1. Honoring Patient Preferences: Advance Directives and Do Not Attempt Resuscitation (DNR) Orders

Objectives

1. Define advance directives: durable power of attorney for health care and living wills
2. Explain the conditions that make an advance directive applicable
3. Define DNAR orders and the conditions under which they apply
4. Define the difference between DNAR orders, MOLST/POLST (medical/physician orders for life-sustaining treatment)-paradigm orders and advance care directives
5. Explain your state laws regarding advance directives and DNAR orders. Which forms of advance care directives are allowed in your state?

Case 3.1.a: Advance Directives

As the base command physician, you receive a call from your paramedics. They were called to a nursing home for a patient in respiratory distress. Upon arrival they found the patient to have agonal respirations and a pulse of 35. The daughter arrived seconds later and says the patient's Advance Directives state she did not want intubation or other cardiopulmonary resuscitation. The daughter asks for the paramedics to leave her mother alone and not transport the patient to the hospital. Written copies of the Advance Directives cannot be found.

Case 3.1.a: Questions

1. *What is your response?*
 - a. Recommend intubation and initiation of advanced cardiac life support protocols followed by transport to the nearest emergency department.

- b. Ask to speak to the daughter and explain that once called the paramedics must transport.
 - c. Tell the paramedics to wait until she becomes asystolic and call back for pronouncement of death.
 - d. Tell the paramedics to leave.
 - e. Other (explain)
2. What would you do if there were written directives or orders that reflected the patient's wishes avoid resuscitation or intubation

Case 3.1.a: Teaching Points

Paramedics should initiate resuscitation if there are no written orders/directives or written documentation of the MDPOA. They should inform the daughter of their policy, and also point out that life sustaining interventions can be withdrawn at the ED when the provider confirms the patient's wishes. MOLST and POLST-type documents make situations like this less common. If the written ADs are available, or if the MDPOA forms can be reviewed, paramedics should honor the daughter's request as spokesperson for her mother. In many EMS systems protocols exist to guide paramedics in these types of situations. In a situation like this, it might be possible with a short transport time to bag-ventilate the patient, apply pacer pads, and transport, choosing the least invasive means of supporting the patient; however intubation and later extubation when the patient's wishes can be clarified may be the best choice.

Case 3.1.b: DNR in the ED

A patient with COPD comes into the emergency department during a severe exacerbation. His pH is 7.02 and his PCO₂ is 84. He indicates that he has been intubated previously and does not want to be intubated again.

Case 3.1.b: Questions

1. *What do you do?*
 - a. Intubate him anyway because he lacks decision-making capacity (DMC)?
 - b. Attempt to find family who may override or confirm his wishes?
 - c. Attempt non-invasive therapy, but do not intubate?
2. Does the patient have decision-making capacity to make this decision?

Case 3.1.b: Teaching Points

Hypercarbia does not automatically mean that a patient does not have decisional capacity. If your patient can describe his choices, the probable consequences and give a rationale ("why"), his wishes should be honored. Unfortunately, conversations needed to clarify his thinking may or may not be possible if he

presents emergently. Often, however, the decision to intubate is urgent but not emergent. Non-invasive ventilation can buy time for family and friends, chart review or PCP contact, and perhaps stabilization of the patient himself -- any of which may confirm the patient's wishes. If the patient's decisional capacity is questionable and non-invasive ventilation is unsuccessful, intubation can be initiated and then removed once the patient's desires confirmed. (See also Module 2-II on decision-making capacity.)

Background Information

Advance Directive (AD): A written document expressing a patient's future wishes or preferences regarding medical interventions and resuscitation. Several formats exist, but all are designed to give a patient control over treatment decisions that will be made when they are unable to participate directly. The two most common types of advance directives are living wills and medical durable powers of attorney (MDPOA). The Patient Self-Determination Act (1991) requires that all hospitals that accept Medicare and Medicaid funds provide information to patients about advance directives and, if a patient desires, develop policies to help patients create them.

Living Wills: Express a patient's wishes regarding life-sustaining procedures in the event of terminal illness. Living wills are narrowly written, which often limits the applicability of the document in the ED setting. When the applicability and circumstances are clear, however, the emergency physician has an obligation to respect the living will. Finally, the patient can revoke a living will at any time, even during a time of crisis in the emergency department.

All states have statutes governing durable powers of attorney. In some states, additional statutes explicitly identify that durable powers of attorney may apply to health care decisions. **Medical durable power of attorney** (MDPOA) is a legally designated decision maker who is given the authority to make medical decisions for a patient if he or she becomes incapacitated. That person then becomes a legally recognized decision maker for the patient if the patient lacks capacity. The MDPOA supersedes family members or others that may be authorized to make decisions according to state law. When a medical durable power of attorney exists, the emergency physician should allow the designated person to make decisions on behalf of a patient who cannot speak for him/herself.

Patients with decision-making capacity or surrogates (chosen by the patient as MDPOA or designated by state-specific surrogacy laws) have the right to decline even life saving treatment. A surrogate decision maker is instructed to make treatment decisions (including those regarding resuscitation) not according to his or her own values, but according to the known wishes of the patient using "substituted judgment." Immunity is generally granted to the physician who carries out the surrogate's decision in good faith. Physicians should be aware of state law, federal guidelines and ethical responsibilities that outline policies regarding health care proxies and living wills. Emergency departments should have guidelines regarding following advance directives.

Do not attempt resuscitation orders (DNAR) are orders executed by physicians (or other health care providers) to withhold cardiopulmonary resuscitation (CPR) and advanced life support (ALS) interventions if a patient is pulseless and apneic. DNR orders limit resuscitation in an arrest, but do not provide direction about what treatments to provide to patients in peri-arrest situations. Traditionally, DNR orders apply to single admissions and are not transferable across institutional boundaries.

POLST-Paradigm Orders: Many states and regions have developed expanded physician *orders* that provide direction about providing or limiting treatment in all situations (e.g. pre-hospital, nursing homes, as well as across admissions). These often include DNR orders and can be useful in the prehospital and ED setting. As opposed to traditional ADs, these are orders that are state-mandated to be honored, and are usually only enacted in the last 6 months of a patient's life. They are often more inclusive (including such treatment options as intubation, antibiotics, fluids, etc) than the more traditional state-specific **CPR Directives**, which only addresses CPR. In addition, they are valid across institutions and for EMS. Patients may be identified by the state-designated form, or often by a bracelet or necklace.

Finally, some comments about AD relevance to EM: if there is doubt regarding the patient's wishes or the validity of a document, resuscitative efforts should be initiated. The decision to resuscitate is an immediate "yes" or "no" decision. "Slow codes," suboptimal effort, or delayed interventions are not medically or ethically acceptable. It is ethically equivalent and sometimes superior to start treatment and then stop it when the patient's wishes become clear. The ED is also a place where patient wishes, including DNR orders, can be initiated by the emergency physician for the upcoming hospitalization following discussion with the patient or the patient's appointed decision makers.

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Module 3: End of Life Issues

- I. Honoring Patient Preferences: Advance Directives and Do Not Attempt Resuscitation (DNR) Orders
 - II. Futility**
 - III. Withdrawing and withholding treatments
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II. Futility

Objectives

1. Consider definitions of futility.
 2. Consider how medical futility may play a role in medical decision – making.
 3. Describe emergency situations in which the patient may wish to invoke futility, even if providers have interventions they wish to try.
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Case 3.2.a: Sepsis resuscitation of terminal patient

An 89-year-old woman presented to the ED with fever and altered mental status. She was diagnosed with uro-sepsis. She also had known, widely metastatic colon cancer. Per the family the patient had been conversant and interactive as recently as the day prior to arrival, but she had lost 60 pounds in the last 2 months and was refusing to eat.

Case 3.2.a: Questions

1. Do you initiate the sepsis protocol?
 2. If she had DNR documentation, what would you do?
 3. Would you admit this patient and let the inpatient team figure it out?
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Case 3.2.b: Patient refusing life-saving surgery but family disagrees

A 95 year-old male with, known 8cm AAA presents to your ED with abdominal pain and hypotension. Your FAST exam is positive for free fluid. The patient states that he does not want surgical intervention, but the family presses you to have the surgeons take the patient to surgery to “do everything” possible to save his life.

Case 3.2.b: Questions

1. What would you do?
2. What should you do?
3. Is this Medical Futility?

4. While you are on the phone with the surgeons discussing the case and treatment options, the patient rapidly decompensates and becomes pulseless. Now what would you do? What should you do?
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Background Information

Medical ethicists and physicians have tried to define “futility” for several decades without consensus. Physiologic or medical futility in the absolute is rare – i.e. patients rarely have zero probability of benefitting from an intervention. However, there are clearly procedures that are not effective, or will not achieve medical goals. (eg. transvenous pacing in asystolic arrest). This might be described as “*Goal Futility*.” Health care providers are not mandated to offer treatments to their patients that are not “medically indicated.” However, for many clinical conditions, the medical indications and prognosis for resuscitative measures are unclear, making this judgment difficult. The physician is obligated, however, to give patients the best information to make decisions near the end of life. These include potential benefits, the likelihood that a proposed intervention can achieve these benefits, as well as the potential for complications, failure or burdens that would be placed on the patient – either by the medical treatment or by not doing the proposed treatment.

Another type of futility might be called “*value futility*.” This is more commonly encountered in the medical setting, and relates to the patient’s desired treatment goals. For one patient, living for a few days may be beneficial because it allows her to say goodbye to family, or permit timely arrival of distant relatives. For another patient, the relief of suffering that death brings is welcome. Thus, it is impossible to tell whether an intervention is futile in this sense without a conversation and ongoing inquiry directed at understanding that patient’s values.

In the ED, professionals will often need to err on the side of stabilization and “life,” because the patient’s values and goals are unclear. While the ED will continue to “over-resuscitate” in the face of inadequate time and information, it is important that the ED physician be comfortable with honoring a patient’s clear wishes regarding certain interventions are unwanted.

Pre-Hospital Considerations:

The AHA has defined parameters for “goal futility” in out-of-hospital resuscitation efforts. Recent research has demonstrated that criteria for termination of prehospital BLS and ALS can be validated and that criteria for “goal futility” can be extended beyond the obvious dependent lividity, decomposition and decapitation. EMS providers are responsible for knowing the guidelines for not starting and for stopping CPR and ALS in their system.

State-sanctioned CPR directives and POLST-paradigm forms are written documentation of a patients’ expressions of value futility. While research indicates that families do not expect that EMS treatment always include transport to a hospital and

many families were satisfied with ending unsuccessful resuscitations at the scene, a clear consensus remains elusive on how to avoid non-beneficial resuscitation and transport attempts.

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3.3. Withdrawing and withholding treatments

Objectives

1. Discuss the ethics of withdrawing and withholding treatments.
 2. Consider the medico-legal environment concerning decision of withdrawing and withholding treatments.
 3. Discuss why it feels harder to withdraw than to withhold treatments.
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Case 3.3.a: Withdrawing Treatments

An 89-year-old woman was brought in by paramedics to the ED tachypneic, febrile, hypoxic, hypotensive, and altered. The patient was promptly intubated prior to the arrival of family. The family then arrived and states that the patient did not want to be intubated or resuscitated in any way. They produce an advance directive with the patient's and patient's primary physician's signatures. The family appears to be in consensus regarding the patient's wishes.

Case 3.3.a: Questions

1. What do you do?
 2. Do you admit the patient? If so, how?
 3. Do you extubate the patient in the ED?
 4. What do you do if the patient inadvertently self-extubates herself? Do you re-intubate?
 5. Is there an ethical or medicolegal difference between withholding and withdrawing life sustaining treatment?
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Background Information

A physician has no obligation to provide non-beneficial therapies. This assessment may not be possible in the ED setting, where decisions may need to be made rapidly. Often information is incomplete and quick judgments that interventions are futile can be dangerous. (see above discussion in Module 3.2 of "futility"). A trial of a less invasive treatments may "buy time" without increasing patient suffering. (e.g. non-

invasive ventilation, peripheral IV fluid resuscitation, positioning, suctioning or mediations directed at symptom control). Such interventions may enable the clinician to gather the information needed to decide what the patient's wishes are and whether continued interventions have any likelihood of benefit.

For physicians, it may feel like “killing” the patient to withdraw interventions after they have been initiated. According to the American Medical Association, “withdrawing life support may seem ethically more difficult than withholding life support because the physician performs an action which hastens death. When life-sustaining treatment is withheld, on the other hand, death occurs because of an omission rather than an action. This action/omission distinction has been used to differentiate between killing and allowing death. However, as most bioethicists now recognize, the action/omission distinction lacks ethical significance.”

In the ED, it is important realize that some interventions are not “emergent.” It is often possible to talk to the patient or surrogate decision maker for a few minutes before launching into a full diagnostic and therapeutic workup. That said, extubation, removing lines, and withdrawing other unwanted interventions can be appropriate in the ED when the patient's wishes become clear. An important caveat before a life-sustaining treatment is withdrawn: while it is sometimes clear that patients will die rapidly, the patient's course after withdrawal of life-sustaining interventions is not always predictable. The ED may not be the best place for families to say ‘goodbye’ and be with a dying loved one. Either before or after removal of life supports, admission for comfort and palliative support is often a good option.

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