Ethical Issues: Part 1
Advance Care Planning, Limiting Life Sustaining Treatments, Comfort Measures

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Objectives

1. Describe principles of advance care planning with older adults.
2. Discuss how “do not resuscitate” status applies to care of older adults with chronic / life-threatening illness.
3. Apply principles of ACP and DNR to 3 paradigm cases.
Advanced Care Planning

A person’s action NOW to assure that her medical wishes will be followed LATER if she loses the capacity to make a decision

- Permits continued respect for patient autonomy and self-determination
- Respects informed consent and refusal
- Furthers patient-centered care
Historical Overview of AD

- Karen Ann Quinlan - 1976
- Nancy Cruzan - 1990
- OBRA 1990 - Patient Self Determination Act 1991
- Terry Schiavo - 2005
- Revised VT Advance Directive Law
  - (VSA Title 18 Part 10, Chapter 231)
  - Effective 2005
- Revised NH Advance Directive law
  - (NHSA Title X Public Health Chapter 137-J-1)
  - Effective Jan 1, 2007
Advance Directives

- Formal written instructions and/or appointment of agent
  - Living Will less useful because problems:
    - Vague terms (‘heroic’, ‘extraordinary’)
    - Activated (typically) only in terminal illness
  - Durable Power of Attorney for Health Care (DPOA-HC)
    - more useful
Advanced Directives are written for Treatment Withdrawal / Refusals.

- Treatment refusals use same elements as informed consent:
  - Adequate information
  - Pt is competent
  - There is no coercion
- Advanced Directives may/should give direction about DNR
- Do Not Resuscitate (DNR) is a particular type of treatment refusal
Durable power of attorney for health care (DHOA-HC)

- In effect only when patient lacks capacity to make health care decisions
- (NH) Patient directs the agent whether or not to withhold/withdraw artificial nutrition/fluids
- (NH) Even when incompetent, treatment cannot be given or stopped over the patient’s objection (unless they waive right in AD-Ulysses' clause)
Family involvement

- DPOA-HC decides **who** should help the health care team know what the pt would want
DPOA-HC

- Ideally, pt should have had discussions with their DPOA-HC about their wishes
- Ideally, DPOA-HC should KNOW they are the DPOA-HC and agree
- At least---DPOA-HC should know the pt well enough to have a sense of their values/beliefs about life, health care and end of life
If no DPOA-HC

- Who makes decisions?
If no DPOA-HC

- Who makes decisions?
  - In both NH and VT NO “next of kin” laws
- Get consensus of involved family/significant others

VS
Living Will

- A written directive of pt’s treatment wishes in effect when patient is incapable of participating in health care decisions
- Patient is terminally ill or permanently unconscious
- May elect to withhold or withdraw artificial nutrition or fluids (must be commented upon in NH LW)
Communicating about Goals of Care: Advanced Directives

- Even w/ AD-Pt is always decision-maker
  - AD in effect ONLY when patient is incapable of participating in health care decisions
    - It often includes designation of Medical decision-maker and defining preferences for care (e.g. “living will”).
    - It should specifically address wishes re: artificial/medically administered nutrition and hydration.
  - If pt certified to “lack capacity” then...
    - Proxy Decision-maker/Durable Power of Attorney for Health Care-uses substituted judgment (what would pt want in this situation) vs. “best interest” standard (what is in this pt’s best interest)
    - Living Will
    - DPOA-HC “trumps” if inconsistencies in LW
Role of the nurse with Advanced Directives

- Understand what a Living Will is, what a DPOA-HC is, and what they are NOT
- Assist pt/family to Understand what a Living Will is, what a DPOA-HC is, and what they are NOT
- Collaborate with health care team to assist patient and their family to understand their health status
- Support pt in deciding who should be their DPOA-HC
- Know where Advanced Directives are documented in your facility’s patient medical records
- Have your OWN Advanced Directives!!!!
- Other??
Advance Directives (AD) & DNR

Distinctions

- An Advance Directive is a statement of a patient’s preferences for care in the event of life-threatening illness.
  - It may or may not include resuscitation preferences.
- A DNR order is a physician/ARNP order, not an AD.
- The DNR order can be acted upon immediately by any health care professional.
- A DNR order specifies **withholding CPR only** and should not be interpreted to mean any other care (like “comfort care only” or “comfort measure only”)

**WARNING:**

- A DNR order specifically orders **no CPR** and must be in place for any resuscitation to be withheld.
- A Code Blue order can be ruled over a DNR order. This is why you should have both in place (DNR and Code Blue) even in the same patient.
Comfort Care

- A philosophy of care for pts at EOL focusing on interventions aimed only at enhancing comfort. Pt is usually DNR.

INCLUDES:
- Hunger/thirst (po)
- Dyspnea
- Elimination
- Oral care
- Skin care
- Psychosocial/spiritual concerns
- Meds for symptom management – comfort only
  - Pain, dypsnea, anxiety, myoclonus, depression, sleep, pruritus, fever, N/V
CPR: What are the indications?

- Acute cardio-respiratory event in otherwise healthy individual
  - Acute MI; arrhythmia
  - Electrocution
  - Poisoning
  - Hypothermia
  - Other acute events
  - Ebell et al 1998
CPR—

What are the contra-indications?

- Chest wall pathology
  - Myeloma, fractures

- Conditions in which the expected survival to discharge is close to 0%
  - Metastatic cancer with declining function
  - Chronic renal failure on dialysis
  - Multi-organ failure
  - Sepsis
  - Severe acute stroke

Ebell 1998
Other Predictors of Poor Outcome

- CPR > 20 minutes
- Asystole

- Ebell 1998
CPR: Survival and Complications

- Hospital patients: 15% survive to discharge
- Chest wall trauma, aspiration: 25-50%
- Persistent Vegetative State: 10%
- Cost to family:
  - Financial
  - Emotional cost of prolonging dying
- Cost to health care team
  - Emotional cost of prolonging dying
  - Ebell 1998
Remember …

- The procedure of CPR was never intended for use in patients dying an expected death from a chronic, fatal, medical illness----Such as today’s three geriatric case studies

- DNR (do not resuscitate) refers to CPR only. It requires an MD/ARNP order for each hospital admission (since patient’s condition/wishes may change) or setting of care.

- New American Heart Association Guidelines for CPR address ethical issues extensively-
  - (supplement to the journal Circulation, 12/13/05) available online at http://www.circulationaha.org. Part 2 (pp. IV-6 to IV-11)
Out of Hospital DNR (OOHDNR)
Question: Is it possible for patients to have their DNR status continued at the Nursing Home or at their home?

Answer: YES,

– any NH or VT adult, regardless of health status can obtain an out of hospital DNR order

Question: Who can complete an OOHDNR on a patient?

– Answer: Any MD/ARNP involved in patients care
Important to include family when discussing issues w/ patient

- Family important part of end of life care
- Family may be DPOA and making future decisions based on pts wishes
- Family has their own needs/concerns
Do decisions ever change?

- How often should people review/revise their AD or DNR?

- How similar are the pt’s and their DPOA-HC views on their care planning?
Ineffective Care (Futile Care)

- **Definition**
  Webster’s Definition: “Serving no useful purpose: completely ineffective”

- **The AMA says…**
  - Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients.

- **Individual clinician judgment about “futile care” varies**

- **National standard- Institutions should develop a process for “Resolving disputes” about futile care rather than a “checklist”**
Problems/concerns

a. with definitions of futile care
b. who makes the decision of what is futile (do surrogates know the quantitative piece, do health care providers know the qualitative wishes of the patient?)
c. who is informed of the decision that the care is futile (patient, family?)
d. what if there is conflict? (Conflict resolution policies and is it ethically ok for someone else to cede to the patient’s/surrogate’s wishes?)
e. staff discord and stress (differing opinions about both quantitative and qualitative facts)
What if there is lack of agreement (pt/family and health care team) about goals of care?
What if there is lack of agreement about goals of care?

- Clinician should review overall prognosis/treatment - Clarify misconceptions, then ask:
  - *What do you know about CPR/DNR?*
  - *This decision seems very hard for you. I want to give you the best health care possible; can you tell me more about your decision?*
  - *What do you expect will happen? What do you think would be done differently, after deciding to be DNR/full CPR, that wasn't being done before?*
AD, DNR, Futile Care: Preventing Pt/Family/Clinician Conflicts

- Open communication among all team members is key.
- Avoid “the DNR” discussion in isolation of other goals of care.
- Discussion is/(should) be done by pt’s “primary clinician”; however nurses and other team members can provide important input and support.
Managing Patient-Family-Clinician Conflicts

- Use time as an ally
  - Ask patient advocates to be involved

- Be aware of reasons for conflict
  - Anger, guilt, dependency
  - Despair about impending loss
  - Lack of trust
  - Dysfunctional families
    - Alcohol, drug or physical abuse
  - Amount of forewarning
    - Chronic, slow deteriorating vs. accident death.

- Consider palliative care or ethics consult
Managing Patient-Family-Clinician Conflicts (Cont)

If CPR is futile, in some facilities, physician may enter a DNR order in the chart for reasons of futility- check your local policy. No ethical obligation to offer other tx like organ transplants, etc.

If performing tx ‘X’ violates your professionalism, you may request re-assignment. This will be addressed within the ability of the institution to provide care to the patient –(DHMC policy on ‘Resolving disputes with pts over requested ineffective therapy’)}
Conclusion to resolving disputes

- Summarize areas of consensus and disagreement
- Caution against unexpected outcomes
- Provide continuity
- Document in the medical record
  - Who was present, what was decided
- Involve / report to other health professionals not present
- DHMC policy on ‘Resolving disputes with patients/surrogates over requested ineffective therapy’
Three Case Studies
Case study one--Predictable, Progressive Decline: Cancer

- Mrs. Colon, 80 yo woman recurrent GI cancer
- Physical:
  - now metastasis to liver, jaundiced, still alert and oriented
  - discomfort mostly from arthritis, now some abdominal discomfort/bloating
- Psychosocial
  - home w/ VNA; 82 yo husband of 60 yrs. is main caregiver
  - Husband has osteoarthritis, heart disease and COPD
  - 2 adult children live at a distance; They take turns staying w/ her
  - Has financial means to have private caregivers
  - No Advanced Directives
  - Code status has not been addressed
Issues in Mrs. Colon Case study related to AD and DNR, comfort care ????

Thoughts?
Issues in Mrs. Colon case study

- No evidence of Adv Directive
  - ?DPOA-HC
- DNR-(outpt)
- Comfort care—
- Other--Wishes for other life-sustaining measures, transfer to a hospital? Nsg home? (If unable to stay at home)
Case Study Two--Chronic, Progressive Illness, w/ Acute Exacerbations: CHF

- Mr. GI Joe-78 yo man retired military, former farmer, widowed, 5 children live nearby, but none can live w/ him and he’s alone

- Physical:
  - s/p runs of VT; -has had multiple resuscitations; now has AICD which has discharged several times
  - EF 15%; amiodarone, intermittent claudication w/ ambulation
  - SOB; PO in the mid 80’s but no serious problems w/ breathing, On O2 ; nasal cannula
  - Former smoker-just quit

- Psychosocial
  - Most care at VA; but has some cardiac care at DHMC
  - Existence is bed – chair; neighbors and kids bring him meals
  - Understands that his hospice home care status is just so he could get “those nice volunteers”
Issues in Mr GI Joe Case study related to AD and DNR, comfort care????

Thoughts?
Issues for GI Joe-CHF

- Widowed, Large family, Who is decision-maker?
- What are wishes for CPR – in hospital, out of hospital?
- In hospital “Partial” DNR (EG DNI)?
- What about other life-sustaining vs comfort care txs/meds, etc. for his CHF/VT?
- Continue AICD?
- On hospice, but what if he can’t stay at home?
Case study Three--Frail, Long-term Dwindling: Alzheimer’s Dementia

Mrs. Phoenix. 76 yo retired, knitting factory worker w/ Alzheimer's living at home w/ some family and paid caregivers

Physical:
- Has had Alzheimer’s for 15 years; bed-bound for last 8 months,
- not able to feed self but can swallow and eats fair when fed by hand
- mostly non-verbal, intermittent responsiveness to voice, occasionally becomes more alert and responsive
- Has been hospitalized for pneumonia x 3 and after antibiotics has returned home to same state
- Developed pressure sore during last hospital admit that seems painful
- Also has osteoarthritis

Psychosocial
- Has some paid and some family caregivers; one daughter is an RN and is the DPOA-HC
- Pt had said her whole life, “I’d never want to live like a vegetable and I’d never want to be in a nursing home”
Issues in Mrs Phoenix Case Study related to AD and DNR, comfort care ????

Thoughts?
Issues for Mrs. Phoenix

- Lacks capacity, but has DPOA-HC
- Is she an out of hospital DNR?
- Pt expressed wishes “not to live like a vegetable and never wanting to be in a nursing home”
- Hospice are at home?
- What if she can’t be maintained at home?
Questions????