A Practical Approach to Medically Ineffective Treatment

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Introduction

• Most common reason for an Ethics consult in our adult population is moral distress on the part of medical personnel when negotiations over the goals of care for dying patients break down.

• Clinicians need a practical plan, not a philosophical dissertation

• Will focus on the evolving process at our hospital, not the underlying ethics.
Brief Overview of Ethics at Holy Cross Hospital

• Informal/Formal consults
• Beginning of life/End-of-life
• Ethical and Religious Directives
  – Includes statement regarding stewardship of resources
• Common misconception that Catholic hospitals do not follow advance directives or write “do not attempt resuscitation” orders
• The Church opposes both euthanasia and assisted suicide.
Brief Overview of Ethics at Holy Cross Hospital

The responsibility to preserve human life through medical science has moral limits. Extraordinary means that may not alleviate the underlying condition and may excessively burden the patient are not obligatory. Moral decisions about the extent of care should be made in terms of the benefit that may be offered and the burdens that may be imposed, assisted by the medical professional’s judgments and a person’s sense of what is appropriate (see reference).

Maryland Catholic Conference- End of Life
www.mdcathcon.org/endoflife
Accessed 11/20/2013
End of Life Care in the Hospital Setting - Challenges

• Many years of experience as Medical Director of MICU at WHC, and Medical Director, Critical Care at HCH. Have seen increasing numbers of terminally ill/end-stage patients in ICUs.

• Physicians are a very culturally diverse group. Many physicians tend to offer all treatments, and let patient/surrogate choose.

• Physicians are very conservative and fear being sued. Even a frivolous suit can be very time consuming and expensive, taking a lot of time from their practice. Not worth it to them to go against wishes of patient/family.
End of Life Care in the Hospital Setting - Challenges

• Disconnect between physicians and hospitals - different priorities. Physicians’ prime ethical duty is to advocate for the individual patient, hospital may see its duty to serve the community as a whole.

• Physicians may get paid for patient visit when hospital no longer being paid for additional days.

• Many physicians receive little orientation to individual Hospital policies and practices, and

• Variability in hospital practices where they admit - can’t even remember passwords!
Challenges- continued

• Community misconception that patients/surrogates have right to demand treatment. Many physicians share this misconception of patient autonomy.

• Discussion of goals of care often not held. Possible reasons: physician uncomfortable, not enough time, no reimbursement, physician believes treatment will work.

• Palliative care still confused with hospice care by both physicians and patients. Involved late, delaying goals of care discussion.
Challenges -
What we saw at HCH

• Perception that an Ethics consult won’t help

• When Ethics was consulted regarding “futile” care, physicians’ perceptions were that they were taking most of the risk. They felt they were being asked to go out on a limb by themselves when going against patient/surrogate directions.

• Many physicians were, and still are, unaware or do not believe an Ethics consult protects them from prosecution.
Evolution/Prerequisites of Our Approach

• Integrate Ethical principles with the process outlined in the Maryland Health Care Decisions Act.
• Obtain support from senior leadership and hospital counsel. Absolutely key.
• Physicians must believe the hospital is fully supporting them.
• Physician to physician communication.
• Determine the comfort level of the clinicians regarding withholding vs. withdrawal. We have much resistance about withdrawal, but willingness to withhold. We accept that. Not ideal (law and ethics permit withdrawal, additional burden on patient and staff as dying process prolonged), but a good step.
Evolution/Prerequisites of Our Approach

• The determination of terminal, end-stage, or vegetative condition is the responsibility of the treating physicians, not Ethics.

• The determination of which treatments are medically ineffective is the responsibility of the treating physicians, not Ethics.

• Ethics may ask for additional medical consultation to confirm treating physician’s determination (eg. Neuro consult)
Evolution/Prerequisites of Our Approach

• Development of wording in Ethics consult that physicians find supportive
• Development of a more standardized Certification of Medically Ineffective Treatment form
• Development of a letter from a member of Senior Management to be given to the family affirming the physician’s plan to withhold/withdraw treatment by a given date unless transfer can be arranged.
PHYSICIAN CERTIFICATION OF CONDITION

This Physician Certification of Condition must be completed by the attending physician and a second physician prior to obtaining consent from a surrogate to withhold or withdraw life sustaining treatment.

A) I ________________, M.D., am a physician licensed by the State of Maryland. I hereby certify that based upon my examination of this patient, ________________, he/she is in:

(circle one)
- a terminal condition
- an end stage condition
- a persistent vegetative state*

(Physician’s Signature)
(Date and Time)

B) I ________________, M.D., am a physician licensed by the State of Maryland. I hereby certify that based upon my examination of this patient, ________________, he/she is in:

(circle one)
- a terminal condition
- an end stage condition
- a persistent vegetative state*

(Physician’s Signature)
(Date and Time)

*For certifying persistent vegetative state, one of the two physicians must be a neurologist, neurosurgeon, or other physician who has special expertise in the evaluation of cognitive function.

Definitions:

“Terminal Condition” means an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery.

“End stage condition” means an advanced, progressive, irreversible condition caused by injury, disease, or illness:

1. that has caused severe and permanent deterioration indicated by incompetency and complete physical dependency; and
2. for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.

“Persistent vegetative state” means a condition caused by injury, disease, or illness: a) in which a patient has suffered a loss of consciousness, exhibiting no behavior evidence of self-awareness of awareness of surroundings in a learned manner other than reflex activity of muscles and nerves for low level conditioned response; and b) from which, after the passage of a medically appropriate period of time, it can be determined, to a reasonable degree of medical certainty, that there can be no recovery.
Physician Certification of Medically Ineffective Treatment

The Physician Certification of Medically Ineffective Treatment must be completed by the attending physician and a second physician prior to withholding or withdrawing life sustaining treatment (including CPR) on the basis that the treatment would be medically ineffective.

(Place ✓ by treatments deemed medically ineffective):

- □ CPR / Defibrillation
- □ Endotracheal Intubation and Mechanical Ventilation
- □ BiPAP or CPAP
- □ Reintubation
- □ IV Vasoactive Drugs
- □ IV Anti-arrhythmic Drugs
- □ Cardioversion
- □ Blood Products
- □ Other ________________________________
- □ TPN
- □ Tube feeding
- □ Antibiotics
- □ Dialysis
- □ Labs / Including fingersticks
- □ Surgery / Invasive procedure
- □ Fluid boluses
- □ Automatic cardiac defibrillator

A) I, ____________________________, M.D., am a physician licensed by the State of Maryland. I hereby certify based upon the current medical condition of this patient, ____________________________, the above indicated treatment(s) will not prevent or reduce the deterioration of the health of this individual or prevent his or her impending death.

   Physician Signature ____________________________ Date __________ Time a.m./p.m.

B) I, ____________________________, M.D., am a physician licensed by the State of Maryland. I hereby certify based upon the current medical condition of this patient, ____________________________, the above indicated treatment(s) will not prevent or reduce the deterioration of the health of this individual or prevent his or her impending death.

   Physician Signature ____________________________ Date __________ Time a.m./p.m.
Ethics consult requested by ______ for question of medically ineffective treatment. (Insert brief summary of clinical situation.)

Patient has no (or has a) written advance directive.

_______ is/are acting as surrogate

Palliative care has/has not been consulted

Patient remains full code.

Impression/Suggest:
There is no ethical obligation to provide non-beneficial, burdensome care. In addition, the principle of autonomy does not grant the patient, or those providing substituted judgment on behalf of the patient, the right to demand non-beneficial care. This patient is clearly (terminal or end-stage or vegetative). Additional aggressive life support measures will only serve to prolong the dying process.

Ethics fully supports withholding those treatments determined to be medically ineffective by the patient’s treating physicians. The Maryland Health Care Decisions Act provides a process for withholding medically ineffective treatments despite the stated wishes of the patient or surrogate. Treatments that may be withheld if found medically ineffective by the treating physicians include, but are not limited to: CPR, vasopressors, antibiotics, blood products, intubation and mechanical ventilation, and dialysis. Ethics would fully support the physicians in enacting this process for this patient as outlined below:

1. Complete the Certification of Incapacity
2. Complete the Certification of Condition form (on paper chart). Patient is clearly (terminal or end stage or vegetative). This form must be signed by 2 treating physicians.
3. Complete the Certification of Medically Ineffective Treatment form (on paper chart) and specify which treatments are medically ineffective.
4. The surrogate must be notified that the physicians have determined certain treatments to be medically ineffective.
5. Orders to withhold those treatments deemed medically ineffective may be written after the surrogate is notified and given one week to find a hospital and physician willing to provide the treatment/s in question.
6. Continue efforts to negotiate goals of care

Note: Worth getting palliative care consult if not already done, and have Spiritual Care involved if not already.
My Wish (but not one of my Five Wishes)

• Maryland hospitals develop similar policies and processes for determination of medically ineffective treatment.

• Agree on “community standard” for meaning of:
  – Imminent/terminal
  – Reasonable time to arrange transfer
    • When patient stable (we typically allow 7 days)
    • When patient actively dying, hemodynamically unstable (we may determine transfer not an option, patient too unstable and allow orders to be written upon informing surrogate) (withholding only, non-escalation).
General Process of Ethics Consultation for Medically Ineffective Treatment in Adults at HCH

• Typically done by one member of the Ethics committee. Committee meeting may be called if needed.

• Direct communication physician to physician is key

• Draft of consult is reviewed by VP of Mission Services, VP of Spiritual Care and Ethics, and Risk Management

• Consult is placed on chart (EMR)
Process
Step 1- Data Collection

• Brief chart review (EMR) for background
• Speak with physician(s) involved in treatment to hear their perspective and concerns. May suggest palliative care consult if one not yet done. If consult is about medically ineffective treatment, ask if physician believes patient to be terminal, end-stage, or vegetative, and willing to sign Certification.
• Review paper chart for advance directives, MOLST, durable powers of attorney. Establish surrogate.
• Review paper chart for Certification of Capacity, Condition, Medically Ineffective Treatment
• See patient
Process

Step 2- Negotiate Goals of Care

- Assure Palliative Care is involved. Invaluable for discussion of goals of care with patient/surrogate, and possibly reach out to patient’s PMD.
- Involve Spiritual Care to support patient/family and possibly reach out to patient’s clergy
- If needed, Ethics participates in family meeting.
- If goals of care can be negotiated, consult is complete
Process
Step 2- Negotiate Goals of Care

• If goals of care cannot be negotiated, patients/surrogates may be informed that certain treatments may be withheld despite their wishes using a process provided by Maryland law, including the option of transfer. This often results in anger/disbelief by the patients/surrogates that there are limits to their power, and that they do not hold all the cards in negotiations.

• Occasionally this actually helps negotiations- hard to negotiate when one side thinks they are omnipotent.
Process
Step 3- Implementation

• Complete Certification of Incapacity as appropriate

• Two treating physicians (not the Ethics consultant) certify the patient to be terminal, end-stage, or vegetative

• Two treating physicians (not the Ethics consultant) complete the Certification of Medically Ineffective Treatment
Process
Step 3- Implementation

• Patient/surrogate informed of treatments to be withheld/withdrawn and given reasonable period of time, usually one week, to find physician and facility willing to provide those treatments. All disputed treatments will be provided during that time. Holy Cross will facilitate transfer if one is found.

• Letter from Senior Management provided

• If an alternative facility cannot be found, orders to withhold/withdraw medically ineffective treatments may be written after informing the patient/surrogate
Observations/Experiences

• Have been contacted by lawyers representing surrogate.
• Surrogates may ask to meet directly with Ethics representative.
• Process helpful if guardianship is under consideration because there is no surrogate. If patient to be comfort care, guardianship often not required.
• Process helpful when surrogate wants physicians to decide what is best. Removes burden from the surrogate.
• Process helpful when surrogate pressured by family or culture- treatment being dictated from overseas.
Case 1

70 yo person, chronic dialysis, Jehovah’s witness, with myelodysplastic syndrome that recently converted to acute myelogenous leukemia. Admitted with hypercarbic respiratory failure and septic shock. No advance directive except MOLST worksheet, signed by physician, indicating full code, and time trial of mechanical ventilation for 120-300 days per surrogates. Chemotherapy not possible per oncologist.
Case 1- continued

- Patient placed on vent, pressors, antibiotics. Palliative care and intensivists spoke with surrogates (children) who were unable to accept that parent was dying.

- Ethics consulted for medically ineffective treatment. Orders to not escalate treatment and to withhold further dialysis written in accordance with our process.

- Patient lingered for 8 days before dying. Children would absolutely not agree to withdrawal of ventilator.
Case 1
Lessons Learned

• This case demonstrates disadvantage of “no escalation” in that dying can be prolonged, other patients could be denied a needed bed, and moral distress of staff. But don’t sacrifice the good for the ideal.

• Treatments ordered on MOLST need not be given if they are determined to be medically ineffective.
Case 2

65 yo person with DM, HBP, PVD, and atrial fibrillation who suffered a hemorrhagic stroke in August 2012. Patient could not be weaned from the ventilator and was trached and “pegged.” Although awake able to track, patient was left non-verbal and unable to follow commands. Patient subsequently developed severe contractures and multiple infected Stage 4 decubitus ulcers with multidrug resistant organisms at chronic vent facility.
Case 2- continued

• Patient was admitted to HCH mid-February for fever, dehydration, and leukocytosis from infected ulcers. Debridement, antibiotics given. Despite treatment, patient had persistent fever and leukocytosis and was determined to have failed treatment by ID. Palliative care was consulted early on and met with the surrogate who was not initially ready to “make any decisions” but a few days later agreed to DNAR.

• Several weeks later (mid-March), an Ethics consult was requested. Comfort care was recommended but was not carried out.
Case 2- continued

A second request for Ethics to see the patient was made in mid-April just prior to discharge back to the vent facility. The patient continued to have intermittent fevers with a WBC count in the 30K range after 2 months of antibiotics in the hospital. A recommendation was made to complete a MOLST form on discharge based on “other legal authority...” indicating no CPR (Option A-1) and no transfer to hospital (option 4c) as treatment for his infected decubs was clearly ineffective. This was discussed with the attending and palliative care service who informed the daughter of the MOLST orders. Patient was finally discharged about 1 week later.
Case 2- continued

Patient was sent back to the ER 2 days after discharge for fever. The MOLST was found and reviewed by the ER physician, and after intervention by case management, risk management, and senior management, the patient was returned to the vent facility.
Case 2
Lessons Learned

• Always have direct communication between hospital physician and nursing home physician if treatment to be withheld due to ineffectiveness. Also nurse to nurse communication.

• Recommend attaching copy of Ethics consult to MOLST so receiving facility can see the process used if using “other legal authority.”

• If using “no transfer to hospital”, use comfort care designation (Option B), not Option A-1 or A-2. Puts ER docs in a bind otherwise.

• Inform the ER when patients being discharged with “no return to hospital.”

• Reasonable to return to hospital for comfort care that cannot be provided at the long-term facility.
Some Other MOLST Concerns

• Worksheet can be signed by physician... valid?
• Patients are unaware of MOLST
• No Spanish version
• Uncertain if there is a more recently signed MOLST.
• If decision made with surrogate’s consent to withhold CPR, there is no way to designate that the patient is terminal/end-stage/or vegetative.
• MOLST does not distinguish between “death prolonging and life restoring” treatments.