MARYLAND HCDA – SURVEY OF HOSPITAL ATTORNEYS AND RISK MANAGERS
SUMMARY OF FINDINGS – JUNE 2010
Maryland Health Care Ethics Committee Network

Forty-five Maryland hospitals were identified as being acute-care, adult, non-VA, non-psychiatric hospitals. A list of 66 lawyers and risk managers (if available, one lawyer and one risk manager from each institution) were identified and contacted via email and telephone, and invited to participate in an anonymous online survey. Lawyers representing more than one hospital were asked to answer the survey based on the largest hospital they represented. Thirty-two individuals responded to the survey between November 2009 and April 2010, representing a 48% response rate. This survey was determined to be exempt by the University of Maryland Institutional Review Board.

Demographics

Eleven (34.5%) were in-house attorneys for the hospital, 3 (9.5%) were an attorney outside the hospital, and 18 (56%) were a hospital staff member responsible for risk management issues (“risk manager”). Eleven (34%) represented a hospital with more than 350 beds, 15 (47%) represented a hospital with between 125 and 350 beds, and 6 (19%) represented a hospital with fewer than 125 beds.

Knowledge of HCDA

Twenty-three (72%) of respondents considered themselves “very familiar” with the Maryland Health Care Decisions Act (HCDA). Eight (25%) considered themselves “somewhat familiar,” 1 (3%) “slightly familiar,” and none “not at all familiar.”

Experiences with medically ineffective treatment certifications

Respondents recalled situations over the last two years in which family members wanted maximally aggressive life support for an ICU patient but the attending physician disagreed with that approach as follows: six (19%) reported this occurring “frequently,” 21 (65.5%) reported this occurring “occasionally,” five (15.5%) “rarely,” and none “never.” Based on responses from the 27 respondents who recalled such cases “frequently” or “occasionally,” the most frequent source of such disputes, in order of perceived prevalence, were: code status (83%), switching to “comfort care” as the main goal (73%), disagreement about who is the appropriate decision-maker (55%), feeding tube use (43%), ventilator use (38%), and dialysis use (21%) (totals exceed 100% because respondents could identify more than one source if they had experienced more than one case at their hospital). Two respondents cited the following reasons: “withdrawal of care,” and “deciding that the patient is actually dead.”

A facility’s ethics committee became involved in such cases “frequently” at 75% of hospitals represented, “occasionally” at 16%, “rarely” at 6% and “never” at none of the respondents’ hospitals, according to survey respondents (3% responded “don’t know”). Regarding how often treatments in dispute were certified by two physicians as being medically ineffective, 12.5% thought this occurred “frequently,” 47% “occasionally,” 31% “rarely,” and 3% “never” (6% responded “don’t know”).

Twenty-nine respondents estimated how many times in the past two years a lawyer representing the patient or family member became involved in disputes between family members and physicians regarding the care of a seriously ill patient. Nineteen cited “0,” six cited “1,” three cited “2,” one cited “5” and one cited “20.”

Respondents who answered this question were asked to estimate approximately how many of these disputes resulted in the filing of a lawsuit. Of the 14 who responded, 11 cited “0,” two cited “1,” and one (who had cited “20” for the previous question) cited “5.”
Most respondents (72%) had not recalled a case in which a physician had decided that a treatment was medically ineffective but they (the respondent) thought the physician was not applying the Maryland Health Care Decisions Act correctly. Nine percent were unsure whether this had happened. Of the six respondents who reported this had occurred, estimates of how many times it had happened were: “3” (x 2), “one; trauma surgeon,” and “2-3x”. Reasons why these respondents felt the physician(s) did not apply the HCDA correctly included “required procedures not followed” (6 respondents) and “treatment was not medically ineffective as defined in the Act” (2 respondents). Qualitative comments included: “The application requires the expertise and clinical judgment of the physicians;” “Did not get two MD[s] to certify;” “The Act is not clear and the physician interpreted it differently than the legal department;” and “[The] Act can be complicated to follow, but the most frequent problem is that the doctors often feel a vent[ilator] needs to be terminated as "medically ineffective" when they feel they are torturing the patient, but this is not within the statutory definition.”

Twenty-one (66%) of respondents recalled a case or cases in which they thought that the attending physician would have been justified under the HCDA in certifying a treatment as medically ineffective, but in which the physician did not do so. Eleven (34%) had not recalled such a case. Of those who recalled such a case, estimates of how often this had occurred. Two cited “1,” three cited “2,” five cited “3 to 4,” and other comments included: “Several;” “multiple – exact number unknown;” “3 to 4 times per year;” “just a few; we have a good proactive Palliative Care Team;” “FREQUENTLY! Physicians and nurses feel their hands are tied by MD law;” and “An affirmative response to this item is dependent upon the interpretation of the definition of medically ineffective treatment and the physician's application of that standard to the circumstances. Given the large number of cases we see on a regular basis, it is impossible to quantify that number.”

Of those who responded “yes” to the above question, the main reasons they believed physicians did not certify a treatment as medically ineffective when it could have been were “fear of litigation” (13 of 26), “belief that the family request to continue the treatment was ethically entitled to be honored (10 of 26);” and “lack of understanding of the law (7 of 26).” Qualitative comments included: “Under Health-General, section 5-613(a)(3), MD law requires continuation of treatment pending transfer where there is a disagreement between the provider and the health care agent/surrogate. In reality, the patient never gets transferred, and we must continue to comply with the wishes of the decision-maker although the provider feels the care requested is medically ineffective!!!;” “Definition of "medically ineffective" treatment in the Act is narrow. There are instances in which medical treatment does prevent or reduce deterioration of the patient, but it does not provide them with quality of life or improve their condition or disease process;” “none of the above; the physician had a personal religious issue;” “I believe the physician sides with the family because it is easier then to not do so not because they feel it is the right of the family;” “desire to work with family to reach mutually agreeable solution;” and “I think many times the physician knows the family and caregivers will get to the right point in the end but the family needs time to come to the understanding that the patient is not going to get better. With more and more estranged families or families with multiple re-marriages and step-children or no marriage and children of various parents, the issues get tougher to work through. It takes families time to work through the process in their mind and [they’re] many times dysfunctional families, and the time frame is not really in keeping with shorter lengths of stay which puts a bind into the process occasionally.

**Views about the Act**

Sixteen of 28 respondents (57%) agreed with a statement that medically ineffective treatment provisions of the Maryland Health Care Decisions Act are difficult to interpret and apply. Six of 28 were undecided—neither agreeing nor disagreeing with this statement. Six disagreed. Four did not answer this question. Seven of 28 respondents agreed to a statement that the medically ineffective treatment provisions are too narrow and do not allow physicians enough discretion in withholding or withdrawing treatment. Substantially more respondents (12 of 28; 43%) neither agreed nor disagreed with this statement; nine (32%) disagreed.
Twenty respondents felt the medically ineffective treatment provisions of the Maryland Health Care Decisions Act support ethically appropriate care, seven felt they do not, and five left this question blank (one was “not sure”). Qualitative comments are sorted by themes as follows:

**Need to clarify HCDA**

“Definitely not!! In fact, we feel that it is in contravention to it;” “The HCP needs more authority to implement when applicable;” “The definition should be modified to address impact on quality of life and/or improvement of underlying disease rather than on prevention or deterioration of patient's health or prevention of impending death;”

“However it doesn't give physicians/hospitals an option when the decision maker disagrees w/ withdrawing care. Although it gives an option for transfer of the patient, there rarely is a place that will accept the patient and the Act provides that everything must be done until a transfer is effectuated.”

“I think they are of some help, but are too vague and limited to provide any real comfort to physicians or hospitals.”

“Making the provision easier to interrupt would decrease the ethical debate when a case is identified.”

**Best approach to end-of-life disputes?**

“The issue is that none of these cases are the same and each one has to be treated as an individual The answer is not always a black or white decision. Each family has to have time to come to terms with the loss or potential loss of someone they love;”

“The medically ineffective treatment provision that requires a physician to provide life sustaining treatment until transfer per family's wishes does (de-facto) force the physician to provide medically ineffective treatment for what may be an indefinite period of time. But the alternative is to allow the physician to unilaterally override the patient's/family's wishes. Which I feel would be more problematic;”

“Keeping a patient alive simply because the technology will allow it does not allow for acknowledgement of the patient's humanity. Families don't understand dying, why the technology looks healing when it's not really, and no one in medicine is willing to have a hard conversation with families about the inevitability of death;”

Yes and No - Yes - The latitude for discretion should be narrow - death is permanent and cannot be changed. No - It is not clear and therefore puts nurses and physicians at risk due to the clarity and difficulty of the general public to understand the law.”

“The right of self-determination should not cease to exist merely because a physician (or 2 physicians) decides that continued medical care is "ineffective." If physicians were permitted to make those final decisions themselves, presumably on the basis that they know what is best for the patient, then why require them to obtain a patient's informed consent for other types of medical care or procedures?”

Physicians often want to substitute their judgment and use quality of life as a basis for their recommendations that the treatment is medically ineffective. The definition of medically ineffective treatment helps to prevent this.

**Positive experiences with HCDA**
“There is enough interpretation for both the MD and family to come to a conclusion;” “Physicians do operate under a fear of litigation. The provision gives them additional permission to provide and suspend the appropriate care;” “I do believe that the medically ineffective treatment provision is useful if the physician utilizes it and the surrogate is then guided through the three options that I mentioned previously;” “We have come a long way to get this verbiage in this Act so we are making some progress;” “Do not find the provisions to cause significant problems at this institution.”

Vignettes

Respondents were asked to respond to three vignettes to determine the likelihood that they would support or oppose physician actions to withhold or withdraw specific treatments deemed medically ineffective according to the Maryland Health Care Decisions Act. See Appendix 1 for the vignettes. See Table 1 for a summary of responses.

TABLE 1. LIKELIHOOD OF CERTIFYING SPECIFIC TREATMENTS AS MEDICALLY INEFFECTIVE.

<table>
<thead>
<tr>
<th>MEDICAL TREATMENT</th>
<th>N</th>
<th>SUPPORT*</th>
<th>NEUTRAL*</th>
<th>OPPOSE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRS. H – Write DNR order</td>
<td>27</td>
<td>52%</td>
<td>0%</td>
<td>48%</td>
</tr>
<tr>
<td>MRS. H – Remove ventilator</td>
<td>27</td>
<td>41%</td>
<td>0%</td>
<td>59%</td>
</tr>
<tr>
<td>MRS. H – Keep on maximum support in ICU</td>
<td>28</td>
<td>36%</td>
<td>14%</td>
<td>50%</td>
</tr>
<tr>
<td>MR. W – Write DNR order</td>
<td>27</td>
<td>52%</td>
<td>11%</td>
<td>37%</td>
</tr>
<tr>
<td>MR. W – Remove ventilator</td>
<td>27</td>
<td>29.5%</td>
<td>15%</td>
<td>55.5%</td>
</tr>
<tr>
<td>MR. W – Withhold on antibiotics</td>
<td>27</td>
<td>18.5%</td>
<td>26%</td>
<td>55.5%</td>
</tr>
<tr>
<td>MR. W – Keep on maximum support in ICU</td>
<td>28</td>
<td>32%</td>
<td>25%</td>
<td>43%</td>
</tr>
<tr>
<td>MRS. B – Write DNR order</td>
<td>28</td>
<td>57%</td>
<td>4%</td>
<td>39%</td>
</tr>
<tr>
<td>MRS. B – Remove ventilator</td>
<td>28</td>
<td>25%</td>
<td>7%</td>
<td>68%</td>
</tr>
<tr>
<td>MRS. B – Withdraw dialysis</td>
<td>28</td>
<td>39%</td>
<td>11%</td>
<td>50%</td>
</tr>
<tr>
<td>MRS. B – Transfer to chronic care facility</td>
<td>28</td>
<td>43%</td>
<td>11%</td>
<td>46%</td>
</tr>
<tr>
<td>MRS. B – Keep on maximum support in ICU</td>
<td>28</td>
<td>39%</td>
<td>4%</td>
<td>57%</td>
</tr>
</tbody>
</table>

* Using a 5 point scale, where 1=strongly support, 3=neither support nor oppose, and 5= strongly oppose, SUPPORT = 1 or 2, NEUTRAL = 3, OPPOSE = 3 or 4.

Respondents were asked to agree or disagree with the statement, after considering the vignettes they reviewed, “I am more likely to support a physician’s decision to withhold or withdraw life sustaining interventions determined to be medically ineffective if the hospital’s ethics committee has reviewed the case and decided that this is ethically appropriate.” Twenty-five of 28 (89%) agreed, and three (11%) disagreed. (Four left this response blank.) Qualitative comments in response to the vignettes are summarized below.

COMMENTS – MRS. H

Defer to family
“Answers based on MD law. We don't ethically agree with this. Will continue negotiating with family through this to get them to understand and come around. Until then, we have to follow their wishes;”

“It is easier to support the family during these difficult times. Even after family meetings, the family feels that they are pressured to make a decision they did not want to;”
“Give daughter time to adjust and include social services and ethics comm in discussions with daughter; also include priest, pastor or rabbi if indicated. If pt not brain dead, continue care until family can accept the outcome.”

“The scenario does not provide information on how long the patient has been ventilator dependant. In addition, I do believe it is fair and reasonable to allow the family a day or so to come to reason with the circumstances. I believe that to intervene in a cardiac or respiratory arrest is not within reason but to wean immediately may be too aggressive.”

**Involve ethics committee**

“Pending ethics consult;”

“Case should first be presented at an ethics consultation with the family and representatives of the ethics committee to make recommendations and then the above actions based upon decisions of the ethics committee.”

“It is to everyone's interest to attempt to appreciate opposing positions. Staff at the hospital would need to work closely with the patient's family, understand the religious implications if any, and involve ethics to determine means to find "middle road" if appropriate. Working with the family to help them understand the impact on their loved one of continuing futile life support must be provided throughout the course of treatment to help family come to terms with the impending loss.”

“I would recommend the dtr/family meet with the Ethics Committee, who are very adept at explaining this process, as well as the law, and getting them to come to agreement and understanding of end of life issues.”

“I would not support immediate withdraw of life support and would encourage further discussion with daughter and possible conversation between the daughter and the ethics committee.”

“A and B cannot be undertaken without a detailed discussion with the daughter, including an offer to transfer care to another practitioner, if one would accept the patient. Also, I could not strongly support C unless there was a referral to the Ethics Committee.”

**Interpretations of HCDA**

“First all of the HCDA procedures need to be followed (e.g. 2nd physician certifying.) Even if treatment is medically ineffective, patient should be kept alive until the daughter's wishes are amended (e.g. via PCAC meeting), a court order is obtained, or the patient is transferred to another physician willing to comply with daughter's wished.”

“If treatment is certified by physicians as medically ineffective, the patient's daughter must be informed that treatment will be withheld or withdrawn as medically ineffective under 5-611. If she objects, the hospital must continue to provide care under 5-613 until the patient's daughter consents to DNR/removal of vent or transfer of the patient to another facility or provider, which is typically not an option, or court order or guardianship appointment.”

“Unfortunately, the vent is not "medically ineffective," because it is keeping the patient alive.”

“Your scenario does not indicate if the daughter is the only person who might be a surrogate under the law. Spouse? Other children?”

“If, in the event of cardiorespiratory arrest, CPR would not likely prevent or reduce the patient's deterioration or prevent the patient's death, I would support the physician's decision to certify CPR as medically ineffective.
However, the intubation and ventilator are desired treatments that are preventing her impending death and should be continued according to the surrogate decision-maker's decision.”

“I would not advocate that the physician take any action that would shorten the patient's life until the surrogate, the daughter, comes to terms with the condition of her mother. We would likely have a family meeting and discuss very clearly the terminality of the mother's condition and that the daughter has several options: agree that her mother is terminal in light of the evidence presented, refuse to accept that her mother is terminal despite the evidence and find another physician to care for the mother, or refuse to accept that her mother is terminal despite the evidence and have mother transferred to another facility that will accept her and continue her care on the ventilator. I would have to recommend that the life support be continued until one of those options is exercised.”

_Fear of liability_

“Although the treatment is medically ineffective, I fear a court would side with the daughter absent an advanced directive and require the hospital to honor the daughter's wishes.”

**COMMENTS – MR. W**

_Support family_

“It is easier to support the family during these difficult times. Even after family meetings, the family feels that they are pressured to make a decision they did not want to.”

“antibiotics depend on the situation; again help family to come to accept the inevitable and is the pt brain dead? Follow brain death protocol with the family.”

“Same rationale as the above question. We cannot just move to cease life-sustaining treatment without the consent of the surrogate, though we cannot continue medically ineffective treatment either. That is why our physicians may delay that certification until the family has come to terms with their decision and that may not always be to go along with the physician's recommendations. We have helped to get the patient another physician who believed that the patient should be given more time.”

_Involve ethics committee/gather more info_

“Pending ethics consult;” “Refer this patient to the ethics committee;” “Ethics consultation would be first required, the above support answers would be given if the recommendations from the committee were as above;” “Would encourage convening ethics committee to provide advice/support to the treating MD.”

“Again, it is essential to work with family throughout this process to better understand the value systems that drive family's decisions regarding health care. Ethics, case management, and physician team should conference with the family regularly;”

“See above comment. We also have an Ethics Director who specializes in End of Life issues who can meet with a family and see if they can come to agreement and understanding. I would advise that first, then the ethics committee if necessary;”

“Is there a POA - Is there a guardian. Have the antibiotics been tried and failed. These answers must be addressed first.”

“scenario doesn't indicate if advanced directive or other surrogates so cannot evaluate”

_HCDA interpretations_
“See above (#14) all of the HCDA requirements not met. Therefore, premature to remove vent, etc. In both instances, I support the eventual withdrawal once HCDA requirements are complied with.”

“While it ultimately a decision to be made by the attending physician, it would appear that treatments are not medically ineffective given that they are preventing or reducing the deterioration of the patient. Even if treatment was certified by physicians as medically ineffective, the patient's father must be informed that the treatment will be withheld or withdrawn under 5-611. If he objects, the hospital must continue to provide care under 5-613 until the patient's father consents to DNR/removal of vent or transfer of the patient to another facility or provider, which is typically not an option, or court order or guardianship appointment. On another note, tests may be performed by the hospital to determine if criteria for brain death exits in which case a certification of medical ineffectiveness would not be appropriate.”

“Again, unfortunately, the vent and antibiotics are effective in keeping the patient alive. By contrast, the DNR would only kick in if the patient would likely die anyway.”

COMMENTS – MRS.

Work with family
“again, the best resolution to these situations is to work with the family in a supportive manner while they come to the best understanding of the treatment and outcome. In most cases, the family only needs some additional time to come to the best decision.”

Involve ethics committee/ other consultations

“Pending ethics consult and possible guardianship proceeding”

“Refer to Palliative care and ethic's committee. Support MD decision with transfer to chronic care facility.”

“Again - dependent upon ethics consultation - however daughter does hold a valid POA, so her wishes are to followed.”

“Would convene ethics committee to provide advice/support to treating MDs & to hear from daughter. Would move to discontinue dialysis before ventilator and plan for transfer out of the ICU.”

Interpreting HCDA
“While it ultimately a decision to be made by the attending physician, it would appear that treatments are not medically ineffective given that they are preventing or reducing the deterioration of the patient. Even if treatment was certified by physicians as medically ineffective, the patient's daughter must be informed that the treatment will be withheld or withdrawn under 5-611. If he objects, the hospital must continue to provide care under 5-613 until the patient's father consents to DNR/removal of vent or transfer of the patient to another facility or provider, which is typically not an option, or court order or guardianship appointment. On another note, tests may be performed by the hospital to determine if criteria for brain death exits.”

“same comment as in first case, for the same reasons. My concern is that the court would not uphold the hospital's decision to withdraw treatment if the family has the option and says it must continue.”

“Again - dependent upon ethics consultation - however daughter does hold a valid POA, so her wishes are to followed.”

“Again we cannot just stop life sustaining treatments without the consent of the surrogate. I am not sure, but sounds like the antibiotics is treating an infection that brought the patient from the chronic care facility, so it
would have to be determined if continuing the antibiotics is aiding in returning the patient to the pre-admission state of health or not. If that treatment is not effective, then it may be time to go the road of ineffectiveness of the other measures that appear to have been in place prior to admission. I think this one hinges completely on the effectiveness of the antibiotics and if the patient can be returned to pre-admission state.”

**General Comments/Suggestions**

**Suggested revisions to law**

“In addition to revising the definition of "medical ineffectiveness", the Act should be amended to implement a time requirement in which the patient/family must effect a transfer if they object to the withdraw or withholding of treatment that has been certified as medically ineffective under the Act (similar to the Texas law). Under the current version of the Act, hospitals are required to continue to provide medically ineffective care until they either obtain consent, effect a transfer, which does not happen, or obtain a court order, which is not an ideal solution given the potential publicity, etc. In addition, the Act should clarify whether life-sustaining treatment may be withheld or withdrawn as it relates to an incompetent individual who does not have a surrogate - the Act is unclear and hospitals often opt to go to Court to obtain a guardian to meet the Act's requirement that the patient or the patient's surrogate be informed that the intent to withhold or withdraw treatment as medically ineffective.

“The Act should be modified to reflect a time frame in which the family must effectuate a transfer if the family does not agree to withdraw care. Texas has such a requirement.”

“To clarify my answer to Q 18 - I do not think the provision is difficult to interpret, but it is very difficult to apply. While the Act provides that the physician does not need to continue "ineffective" care to the patient, it also provides that the physician shall continue to comply with the "ineffective" care until care can be transferred to another provider willing to continue the care as requested by the decision maker. If another provider is not willing to continue the care, presumably the original physician must continue in the care. So, although there is a provision, there is often no answer.”

“Our biggest challenges occur when the State is involved as a guardian. Sometimes slow to respond, which is unfair to the patient and there are sometimes variable approaches based on the involved individual.”

**EOL care, palliative care, & law**

“I think everyone--families and healthcare providers--struggle with the notion of death and its inevitability. People just cannot openly talk about death.”

“Re: the transfer issue, when we attended a meeting with other hospitals last year re: this issue, one of our physicians asked, "What if there is a disagreement between the physicians and the decision-maker?" He was advised by the speaker, "Just practice good medicine and forget about the law."

“We have a Proactive Palliative Care Team that has been in effect here for 11/2 years This team has been a great benifit to the end stage patient, families and the healthcare team.”

“In my experience, a physician- usually the intensivist, explains to the family in terms they understand, about the recommendations for continuing or discontinuing care. If the physician is well trained in handling end of life conversations with families, then they tend to make decision more readily and in line with what the medical team deems appropriate.”

**Education**

“Publicity needs to be done to the general public to encourage them to complete documents for end of life care.”
I think the act is a good one but at times difficult to apply in some of today's crazy family situations. I think the Domestic Partner addition is very helpful but I have a real problem with many attorneys writing advance care documents for patients that visibly provide hospitals with a conflict from the start such as writing them with the children having joint and equal authority to act - then we have to get sometimes 5 or more siblings to agree to each and every decision and that is just so wasteful of time left for the patient. Some patients think they have their advance planning done when in fact they have a financial POA rather than a medical directive - so frustrating for the family and for us, though we usually are able to allow that person to consent under the surrogacy provision. Then it is difficult to apply directives from other states that do not have the same requirements for the documents as Maryland, the documents pre-date the act, etc. But I have to say that the climate is improving and many more patients and family's are more well-informed than in previous years.”

General comments on survey

“I would be very interested in seeing your results. The questions were very well thought out and the scenarios were real life events that we all probably face;” “Why is there no mention of palliative care in this survey?”
APPENDIX 1 – VIGNETTES

Mrs. H

Mrs. H. Mrs. H is a 70 year old woman who is admitted to your hospital with respiratory distress from a partial lung collapse. She is put on a ventilator and sent to the ICU. She remains non-communicative, very heavily ventilator dependent, and unable to be weaned from the ventilator. Tests show widespread cancer throughout the lungs and into the bones. Mrs. H’s daughter fervently believes that her mother will recover, and insists that she be weaned off the ventilator. An attempt was made to do so, but Mrs. H could not breathe on her own. The physician believes her death is inevitable and that she can be kept alive somewhat longer on the ventilator, but this will only prolong the dying process. The daughter is adamant that “everything be done” to keep her mother alive. Mrs. H does not have an advance directive.

Using a 5 point scale, where 1= strongly support, 3=neither support nor oppose, and 5= strongly oppose, how likely would you be to support or oppose the following physician actions?

Mr. W

Mr. W A 25 year old man with pneumonia, Mr. W., is transferred from a long-term care facility to your hospital’s Emergency Department. He has been in a persistent vegetative state (PVS) for the past year after surviving a gun shot wound to the head. He has a tracheostomy (opening in the throat for a breathing tube) and is ventilator-dependent. Since his gun trauma, he has been in and out of the hospital multiple times for ventilator-dependent pneumonia, which has been successfully treated with antibiotics. His father insists that everything be done to keep him alive. However, hospital staff question the worth of continued treatment given his irreversible loss of consciousness.

Using a 5 point scale, where 1= strongly support, 3=neither support nor oppose, and 5= strongly oppose, how likely would you be to support or oppose the following physician actions?

Mrs. B.

Mrs. B. is an 81 year old woman with end stage renal disease who had a large hemorrhagic stroke 8 months ago, leading to a very poor prognosis. She is receiving antibiotics for a systemic infection and other interventions to keep her blood pressure and heart function stable. Her daughter is very excitable and constantly at her mother’s bedside, insisting that everything be done to keep her mother alive. On this admission from a chronic care facility, Mrs. B. has been in the medical intensive care unit for one month now. She is ventilator dependent and receives kidney dialysis. She does not speak or respond to questions, although she does occasionally open her eyes with a blank expression which the daughter (but not the medical staff) interprets as intentional. She frequently grimaces and moans when touched as part of routine care, which the nursing staff interprets as indicating pain. In the physician’s best judgment, if Mrs. B. is taken off the ventilator, she will die within minutes. Without kidney dialysis, she will die within weeks. If all of the technology is continued, she may live for several months, although this is uncertain. The attending physician has told the daughter that machines are keeping her mother alive. He strongly recommends a comfort care approach. A chronic care facility could provide comfort care while continuing mechanical ventilation and kidney dialysis, but could not administer the type of life support the patient is receiving in the ICU (for example, IV medications to stabilize blood pressure and treat systemic infection). The daughter continues to insist that her mother receive aggressive life-prolonging therapy in the ICU. The daughter is the appointed health care agent. There is no living will.

Using a 5 point scale, where 1=strongly support, 3=neither support nor oppose, and 5= strongly oppose, how likely would you be to support or oppose the following physician actions?