MARYLAND HCDA – SURVEY OF ICU PHYSICIANS
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. Contact persons were identified at each hospital via email and telephone contacts, and these individuals were asked to distribute an anonymous online survey link to physicians at their hospital who oversee care of adult patients in the intensive care unit (ICU) setting (i.e., attending physicians, hospitalists, fellows, and residents overseeing care of patients in surgical or medical adult ICUs). The survey link was open between November 2009 and April 2010. Forty-five physicians responded to the survey. Attempts were made to define the sample pool to calculate a response rate by asking hospital contacts to estimate the number of qualifying physicians at their hospital. However, missing data precludes calculating a response rate estimate. The findings of this survey are thus considered exploratory. This survey was determined to be exempt by the University of Maryland Institutional Review Board.

Demographics

Forty-eight percent of the respondents were community-based or university-affiliated physicians with hospital privileges, 31% were hospitalists, and 26% were a fellow, intern, or resident. Physicians affiliated with hospitals with more than 350 beds comprised 42% of the sample, those with hospital bed size between 125 and 350 comprised 51% of the sample, and those with hospital bed size fewer than 125 comprised 7% of the sample.

One fourth of respondents reported being “not at all familiar” with the Maryland Health Care Decisions Act. About one-fifth reported being “slightly familiar,” about 39% “somewhat familiar,” and 16% “very familiar.”

Experiences with medically ineffective treatment certifications

A majority of respondents (57%) recalled frequent 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. Thirty-four percent thought this occurred only “occasionally,” and 9% thought this occurred never or rarely. The most frequent source of disputes in these cases, in order of perceived prevalence, were: code status (84%), switching to “comfort care” as the main goal (73%), ventilator use (59%), dialysis use (34%), disagreement about who is the appropriate decision-maker (32%), and feeding tube use (23%). One respondent also cited “lack of trust between family and caregivers.”

A facility’s ethics committee became involved in such cases “frequently” at 28% of hospitals represented, “occasionally” at 33%, and “never” or “rarely” at 35%, according to survey respondents. Regarding how often treatments in dispute were identified as being medically ineffective, 11% thought this occurred “frequently,” 22% “occasionally,” 36% “rarely” and 20% “never.” Of note, over half of the respondents reported that certifications for an ICU treatment being withheld or withdrawn based on medical ineffectiveness criteria were never or rarely done at their hospital.

Most respondents (73%) had not recalled a case in which they had decided that a treatment was medically ineffective but a risk manager or lawyer for the hospital said that they were not applying the Maryland Health Care Decisions Act correctly. Thirteen percent were unsure whether this had happened. Of the 14% who reported this had occurred, estimates of how many times it had happened were: “3 to 5”, “at least 4 times in the last 3 years,” “a few cases,” “6”, and “2” (with 2 leaving this response blank).

Four of 44 respondents (9%) recalled a case or cases in which another physician had decided that a treatment was medically ineffective but a risk manager or lawyer for the hospital said that the physician was not applying
the Maryland Health Care Decisions Act correctly. Twenty-three percent were unsure, and 66% had no recollection of this occurring at their hospital. Of those who responded “yes,” one responded that this had happened a “few” times, and another “10” times. Regarding perceived reasons why the risk manager or lawyer thought the law was not applied correctly, one respondent thought the lawyer felt the treatment was not medically ineffective as defined in the Act. Other comments included: “[There are] differing interpretations of the law. Specifically, that there is no specification as to when reasonable efforts to find alternative care have been exhausted;” “Liability concerns;” “Our hospital lawyer feels it is too risky to EVER say medically ineffective;” “Afraid of getting sued;” “Concerns for lawsuit as ‘medically ineffective’ is vague;” and “don’t know.” One respondent wrote: “To the best of my knowledge, our hospital has never written a DNR order against the wishes of the POA.”

Twenty-four out of 43 respondents (56%) recalled one or more cases in which they thought a treatment could have been certified as medically ineffective but was not, 25.5% had no recollection of this happening, and 18.5% were unsure whether this had happened. Of those who had experienced this, estimates of frequency included “1.5,” “2,” “4”, “many” (for 3 respondents), “10,” “dozens,” and “more than could be counted.” Qualitative comments included: “Unclear. We've pretty much given up on this except in the most extreme circumstances. Even then, our Office of General Counsel won't challenge the family for guardianship;” “Frequently, pertaining to dialysis and ventilator support. The problem is that these measures might be effective short term but not long term and thus, disagreement ensues and ongoing support is provided with poor results.”

Of the 24 respondents who had experienced identifying a treatment as medically ineffective but not certifying it as such, 18 identified the main reason for their not doing so. Seven identified the main reason as: “fear of litigation” seven as “belief that the family request to continue the treatment was ethically entitled to be honored;” one as “lack of understanding of the law;” and several as a combination of fear of litigation plus other factors.

Qualitative comments included: “[The] MD is essentially powerless when [the] family requests the treatment;” “Interpretation of the law (that we have to render all care indefinitely unless we find another physician and hospital to accept the patient), fear of litigation (the deceased don't sue, the survivors do), and fear of bad publicity if we challenge families for guardianship in court;” “Fear of litigation, and belief that the individual was entitled to therapy as it may be effective short term but with dismal burden of treatment and poor long term outcomes;” “In addition to a possible lack of clear understanding of the law, probably, also, to give the family more time to come to terms with and understand the situation and maybe, in part, even the fear of litigation;” “I think we as physicians try to avoid direct conflict with families whenever possible and try to work things out over time. We are dealing with distraught people who are going through possibly the most difficult time in their life and it often seems more productive to gradually have them come to terms over things or not then absolutely declare something "medically ineffective" despite their wishes. In addition to altruistic reasons, the fact that angry families sue is certainly in the back of my mind and no one wants to go through that even if their position/actions are justified by the law. Lastly, as a fellow, I have worked with attendings who tend to push on past when I think further treatment is medically ineffective, which was the case in one of the 4 where ECMO was performed on a patient for 13 days prior to us withdrawing care with his family at bedside;” “The easier route was to go along with the family's wishes rather than instigate a "fight;" and “I do not know the legal precedents for people suing and those cases making it to court when this law is employed. Even a case that makes it through the 1st few steps and eventually gets thrown out is a major stressor, time drain and hassle.”

**Views about the Act**

Almost half of respondents (46%) agreed with a statement that medically ineffective treatment provisions of the Maryland Health Care Decisions Act are difficult to interpret and apply. Slightly more (49%) were undecided—neither agreeing nor disagreeing with this statement. Only 5% disagreed. Thirty-one percent of 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 (59%) neither agreed nor disagreed with this statement; 10% disagreed.

Thirty-four percent of respondents felt the medically ineffective treatment provisions of the Maryland Health Care Decisions Act support ethically appropriate care, 18% felt they do not, and 47% were undecided. Qualitative comments are sorted by themes as follows:

**In support of the law in context of good end-of-life care**

Several respondents commented that the law works if physicians are doing their part to provide good end-of-life care, to communicate with patients and families, and to include the hospital ethics committee when appropriate. Comments included:

“The law allows the physician with knowledge of [the] disease and family to be proactive for the [patient] at [the] end of life and to bring dignity to it.”

“While one person alone may find it a little difficult to be certain that he/she is being objective and appropriate when interpreting the Maryland law, in most, if not all, the cases that an ethics consult had been called to help decide [an] appropriate course of management, the ethics committee was successfully able to interpret the law and apply it appropriately to the situation and arrive at a satisfactory decision with a reasonable explanation for the same.”

“[The law] require[s] a second supporting opinion and … discussion with the appropriate decision-maker with involvement of the Ethics [Committee] as well. However, Physicians must realize that these certifications are an ongoing part of the care discussions and not a way to stop them cold.”

“… I do not think it is the law that is what hinders withdrawing treatment from patients when the family objects. A large part of our job as ICU physicians is helping families as well and if a family will be more at peace knowing that we "tried everything" before their loved one dies, I try to respect that. Again, I am inclined not to even address treatments that I feel would be medically ineffective such as dialysis with these families, though.”

“In my experience, patient surrogates often will make decisions not consistent with what is outlined by the patient plan of care due to feelings of guilt or inability to let go. Often families act for themselves and consider their emotions rather than what is best for the patient. They may do it subconsciously. I have seen that most disputes among family members arise when one member is not coping well. They bring their own emotions in the decision making process and it clouds their judgement. This leads to a stalemate among family members and a lack of any decision making. The care team is often left with their hands tied.”

**Law needs to be clarified**

Several respondents felt the medically ineffective treatment provisions of Maryland’s law are “too vague” and “difficult to interpret.” One wrote, “[the] law is too vague. It should explicitly indicate what conditions are futile, such as crippling ventilatory dependence (including provisions for PFT parameters), crippling cardiovascular disease (such as NYHA class IV heart failure), or crippling neurologic diseases such as persistent vegetative state, brain death, minimally conscious state, or irreversible coma. Unless the law is unambiguous, there will always be fear of legal reprisal.” One felt that in addition to making the law “more clear,” there should be “more effective ways to enforce [sic] it.” One wrote: “[The] law is far too vague. It
should be explicit to the point where decisions of end-of-life care are standardized, without requiring the kind of prolonged discussions that currently exist with families."

One respondent stated, “The Law must provide specific and objective grading criteria for assessing a patient’s condition as terminal. It must not be left to the individual MD to decide that the QUALITY of life is not worth living. Once PROVEN that treatment is in fact FUTILE (i.e. pt will die even with the treatment given) then MDs should be PROTECTED BY LAW from litigation if they apply the standard. Perhaps a STATE MEDICAL Review board should hear these cases and their decision should stand. The treating MD can present case but that MD would not vote on decision to remove life support. An independent panel would base decision on OBJECTIVE CRITERIA with SCORING SYSTEM.” Another opined, “Only a law school graduate, or one of our brain damaged patients, could render the bizarre interpretation of the MHCDA as that of our OGC. But given the state of Baltimore’s jury pool and some of those who sit on the bench who are no more decisive than the OGC, perhaps it is understandable and the law should be clearer so that it cannot be misinterpreted by preschool children, hospital lawyers, or municipal court judges.”

Another respondent wrote: “[The] law is useless in [its] present form. No one (MDs or Ethics Committee) has guts to exercise this "right" due to fear of litigation. Revised law MUST not only protect MDs but ALSO it MUST protect PATIENTS from MDs who would confuse "medically ineffective therapy" with the situation where we can easily save a life BUT disagree on the QUALITY of that life--which is NOT our right to judge!”

**Need education/raise consciousness**

Several respondents commented that they were not familiar with the specifics of the law (e.g., “I need to be educated about the specifics of the law. I have never read the actual pertinent passages;” and “I have never read this law so I don’t know the details. I would strongly rely on advice [sic] from people who are thoroughly familiar with the law.”). One respondent wrote, “[The law] encourages ethical care but [there is] not enough support for physicians providing the care & having to deal with families’ response to [the] process.” Another stated, “[The law is] ethical, but physicians still operate under the fear of litigation and continue to provide futile therapy. An effort to educate physicians and public is necessary;” “More education for physicians and public necessary.” One respondent commented: “I like the act and support its provisions. The state needs to publicize it more.” And another wrote: “I rarely complete surveys but hope something can change as a result of this survey-- we need a culture shift and physicians need to be educated about what they can expect if they go against a family citing this act. There are HUGE amounts of futile care and money being wasted but it is hard to be a crusader and generate a lawsuit (even if it is destined to be thrown out) without more cultural and legal support-- ethics [committee] saying it’s OK is not enough.”

**Scarce resources**

One respondent pointed out the need for limit-setting at the end of life: “Medical care at some point will have to be limited. Giving all out [medical] care to obvious terminal [patients] makes no sense.”

Another stated: “I believe there needs to be a financial cap on ICU resources with exceptions for those who have good prognoses. Families sometimes refuse to listen or are irrational and then we deliver expensive, often uncomfortable care that the public is paying for because of fear of litigation or bad publicity.”

**LSTO Form**

Regarding the “Instruction on Current Life-Sustaining Treatment Options” form (formerly called the “Patient’s Plan of Care” form), which was instituted in Maryland in 2003 to facilitate end-of-life decision-making (e.g., for patients transferred to hospital Emergency Departments from long-term care facilities), respondents were asked whether they think it provides useful information to staff in the Emergency Department, and to others if
the patient is admitted. Twelve of 39 (31%) responding to this question had no experience with the form; 25 of 39 (64%) felt the form provides some useful information, and 2 of 39 (5%) felt the form does not provide useful information.

**LSTO Form Positive comments:**
“It provides caregivers with a clear indication of what the patient's and/or power of attorney's preferences are;”
“It provides an insight into whether a patient would've wanted life sustaining/prolonging measures, eg., ventilator, if there was no reasonable chance of recovering from the illness. While it may not necessarily be a great way to determine the code status, it is certainly very useful when the question of whether to continue the aggressive treatment options in face of poor prognosis arises;”
“helps if patient is DNR;”
“whatever is on the form is generally followed in the hospital unless specifically changed by the POA or patient for that admission;”
“If we don't have information we always err on the most aggressive treatment. It is always good to have direction;”
“the form gives patient patient /family preferences;”
“Helps to guide family discussions. If they were DNR, will continue to honor this as "patient's wishes."

**LSTO Form Critical comments:**
“Many times the family will request ‘everything be done’ because they are afraid care providers in a nursing facility will ignore their loved one;”
“It helps some but families often override it;”
“Forms most of the time not detailed enough regarding specifics;”
“Sadly, patients have no resuscitation orders and still get transferred from nursing homes despite dnr-b status;”
“rarely if ever completed;”
“When the Nursing Home actually manages to send the form to the ER and the ER doc looks at it BEFORE intubating the pt, it can be useful. Things get sticky when they "find" the form AFTER intubation and pressors are begun. What then happens is that the pt is cared for VERY aggressively with intubation, central line, pressors, multiple CT Scans/diagnostic tests, blood cultures, antibiotics, multiple consults to specialists etc, only to be withdrawn from vent 12-18 hrs later by Palliative Care BEFORE pt can respond or not respond to treatments above. This seems somehow unethical and wasteful of human and monetary resources. It also sometimes leads families to question the initial DNR decision made at NH if the ER doctor recommends intubation ‘to save Mom's life.’ Frequently the DNRs are ignored in ER unless a vocal family member is present to reinforce that decision made at NH;”
“Not as useful as it could be in that the options are not binding and the form may not even be completed by the legal surrogate decision maker. While hospitals CAN accept the requests noted (and those of the MIEMS form as well), many choose not to do so noting the above concerns;”
“Very limited information, and certainly not legal documentation of wishes, so not too useful;”
“Unfortunately too many times patients come in with one of these forms with a reversal of the DNR status in the ER;”
“Form is often ignored, as it is vague and considered unreliable. It only provides a start to discussions of decisions regarding end-of-life care;”

**Vignettes**

Respondents were asked to respond to three vignettes to determine the likelihood that they would certify specific treatments as 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>LIKELY*</th>
<th>UNSURE</th>
<th>UNLIKELY*</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRS. H – Write DNR order</td>
<td>40</td>
<td>42.5%</td>
<td>2.5%</td>
<td>55%</td>
</tr>
<tr>
<td>MRS. H – Remove ventilator</td>
<td>40</td>
<td>25%</td>
<td>12.5%</td>
<td>62.5%</td>
</tr>
<tr>
<td>MRS. H – Keep on maximum support in ICU</td>
<td>41</td>
<td>49%</td>
<td>10%</td>
<td>41%</td>
</tr>
<tr>
<td>MR. W – Write DNR order</td>
<td>40</td>
<td>35%</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>MR. W – Remove ventilator</td>
<td>40</td>
<td>17.5%</td>
<td>12.5%</td>
<td>70%</td>
</tr>
<tr>
<td>MR. W – Withhold on antibiotics</td>
<td>40</td>
<td>15%</td>
<td>10%</td>
<td>75%</td>
</tr>
<tr>
<td>MR. W – Keep on maximum support in ICU</td>
<td>40</td>
<td>57.5%</td>
<td>15%</td>
<td>27.5%</td>
</tr>
<tr>
<td>MRS. B – Write DNR order</td>
<td>39</td>
<td>41%</td>
<td>8%</td>
<td>51%</td>
</tr>
<tr>
<td>MRS. B – Remove ventilator</td>
<td>39</td>
<td>18%</td>
<td>13%</td>
<td>69%</td>
</tr>
<tr>
<td>MRS. B – Withdraw dialysis</td>
<td>39</td>
<td>25.5%</td>
<td>20.5%</td>
<td>54%</td>
</tr>
<tr>
<td>MRS. B – Transfer to chronic care facility</td>
<td>39</td>
<td>26%</td>
<td>13%</td>
<td>61%</td>
</tr>
<tr>
<td>MRS. B – Keep on maximum support in ICU</td>
<td>40</td>
<td>50%</td>
<td>22.5%</td>
<td>27.5%</td>
</tr>
</tbody>
</table>

* “Likely” = ”Very likely” + “Likely;” “Unlikely = Very unlikely” + “Unlikely”

Respondents were asked to agree or disagree with the statement, after considering the vignettes they reviewed, “I am more likely 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.” Seventy-seven percent agreed, and 23% disagreed. Qualitative comments in response to the vignettes are summarized below.

COMMENTS – MRS. H

**Involve Ethics Committee/Consultants**

“Would involve ethics committee and readress comfort care with family;” “Would contact the ethics committee for guidance here and request pulmonary/internist consultation. I would not violate the daughter's wishes;” “I would want consultation with the ethics committee;” “Would request an ethics consult;” “Would consult ethics committee, request second physician assessment and certification;” “I would definitely consult the hospital ethical advisory committee before doing this.” “Would use Pt Care Advisory process to get neutral input if family agrees.”

**Avoid adversarial option**

“In reality, if the Patient's family is not willing to let go, We try to convince them rather than use the Law mentioned;” “It can take time for a family to come to grips with the situation.”

**Defer to surrogate**

“It appears that the illness is terminal. Providing CPR would most likely be ineffective, but in the absence of advance directives, the next-of-[kin] is the decision maker for the patient. Unless here is a reason to believe that the patient's daughter is not acting in the best interest of the patient, or there are other family members contesting the soundness of the daughter's decisions is not good, then her wishes must be respected. There is a time element that need[s] to be discussed with the daughter, which is for how long the Hospital will provide aggressive treatment, and what would be the criteria to withdraw intensive supportive care.”

**Instituting HCDA**

“I would write a DNR order only after informing the family that resuscitation would be medically ineffective. I would offer the option of transferring the pt's care to another physician.”
If our local lawyer would accept it, then I would be comfortable getting a second opinion of medically ineffective care and then writing that order. I have done it in other Baltimore area hospitals where this is done. We then gave the family the option of transfer to another facility if they were insistent on continuing aggressive care.

As regards the code status, there is really very little chance of her making it through a code and having any sort of meaningful life thereafter- it does seem like a medically ineffective treatment option for her. Keeping her on continued ventilatory support doesn't seem to be very reasonable with her overall poor prognosis with the widespread metastatic cancer and the partial lung collapse, as well as inability to wean her off the ventilator. So, while an attempt should be made to have the daughter (who I assume is the appropriate decision maker in this case) understand the futility of this as well, if this fails, one could probably discontinue the ventilator based on medical ineffectiveness.

“The law is too ambiguous to act without fear of reprisal by lawsuit.”

**Lack institutional support**

“[We receive] no back up from risk management and hospital [committees].”

“[I was involved in a similar case] in which the daughter … also challenged my order for a morphine drip. Fortunately, we were able to palliate [the patient] with [hourly] intermittent morphine. It is also the case where I was informed by RM that if I went against the daughter's wishes based on 2 physician certification without getting guardianship, essentially following General Counsel's interpretation of the Maryland Health Care Act, the Trust could refuse to cover a malpractice claim against me, although unlikely. The patient died a natural death while in the MICU on full life support, and despite CPR in adhering to daughter's demands.”

“MD is powerless when family requests tx. Unfortunately, MD are there to treat as the decisions are made on a different level.”

**Fear of lawsuit**

“I would ethnically feel comfortable removing life support in this case but I would have lingering concerns about being sued--even with the blessings of the Ethics Committee. So, unless the law is given more teeth, I would not boldly deny the daughter's wishes but would try to pare down treatment where possible and talk to daughter daily to establish rapport.”

“Unfortunately, few physicians are willing to do this for fear of litigation. I have offered families to step out of the case and obtain another treating physician and even in this situation, have been sued after I transferred the care to another physician 72 hrs prior to the [patient’s] death... [the] law suit [is] ongoing in its 5th appeal by [the] plaintiff.”

**Palliative involvement**

“In this case I would personally not just remove the vent and therefore would need to keep the pt in the ICU. I do feel very comfortable writing a DNR in this situation because certainly chest compressions in the last moments of life are ineffective. I would have daily family meetings though and try to help the daughter see what she is doing to her mother and the fact that the best case senario is her dying on the vent in pain rather than comfortably off of it in a more palliative environment. I certainly would get palliative care involved as well.”

“i have no issues in deciding medically ineffective rx and have used the law in the past. however nuance with families is paramount. our palliative care staff does an excellent job”
COMMENTS – MR. W

Contact ethics committee
“Contact the ethics committee for guidance;” “request ethics consult and second physician assessment and continue multidisciplinary approach with family;” “Would suggest ethics consultation and spiritual support;”

Follow family’s wishes
“I would not violate the family's wishes for continued support;” “This patient is endstage but not terminal. I would not be comfortable withdrawing support;” “Patient and family determine their definition of quality of life, not the provider. His process, pneumonia can likely be treated to cure;”

Persuade family to consider less aggressive treatment
“Take [the patient] through active infection and then discuss with family the long time goal in more relaxed situation;” “Would try to convince the father [to consider less aggressive treatment];”

Favor physician decision-making
“It is time physicians take over management of terminal pts and not accede to impossible and unrealistic family requests, doing everything should be from the providers expertise not from the family menu of health care options;” “Would use ventilator & antibiotics as reasonable and potentially effective but intensity of care beyond these modalities would be influenced by clinical situation and likely complications at the time.”

Lack of institutional support
“In [similar] case, the organisms had grown resistant to all antibiotics except polymixin B and we were on last line therapy. If this didn't work (it wound up working and we placed the patient) there was nothing else to offer. Family was unreachable. Two of us certified. But it wasn't accepted by OGC without guardianship.”

Meeting definition of medically ineffective
“Witholding antibiotics seems unreasonable, since it doesn't seem consistent with medical ineffectiveness-they have been effective in treating his pneumonia in the past. It does not seem like death would be imminent or that treating this episode of pneumonia would be futile. Discontinuing the ventilator seems inappropriate, if indeed the patient would've wanted everything done to keep him alive, since he has been in the PVS for more than a year and there is no other illness/disease that would otherwise suggest imminent/eventual death irrespective of treatment. The chances of the patient making it through a code seem very low and hence this might seem like an unreasonable medical treatment.”

This patient has survived several bouts of pneumonia before. Therefore, giving antibiotics is not medically "ineffective." He likely will recover from the pneumonia. He is in a PVS and this is an acceptable quality of life as far as the patient's father is concerned and we have no right to judge that even if we would decide differently for our child. The bottom line is that we can save this patient and should.”

“PVS doesn't mean impending death, so I would be less aggressive in challenging the family's wishes.”

“What's right” versus “what happens”
“I know these are not the right answers, but it is what happens.”

Scare resource consideration
“This patient has been kept alive artificially, as he is ventilator-dependent. There is no possibility of neurological recovery after he was shot in the head. Because he is young, the possibility of keeping him alive for a long time with intensive and aggressive care is high. This issue needs to be considered based on the scarcity of resources and the real possibility of denying a bed to a patient who has a higher potential to recover.”
COMMENTS – MRS. B

Consult ethics committee/consultant
“Again, contacting the ethics committee at the hospital would occur;” “I would need an ethics consult;”
“multidisciplinary approach to POA, ethics consult and second physician assessment;” “I would strongly get the
advice of the ethics committee. Care has been provided for a month and the possibility of recovery is minimal.”

Follow surrogate
“The patient's appointed agent mandates the care;” “This is what I would do, despite it being a terrible use of
resources;” “Death is not imminent, but patient is end-stage. I would be comfortable not adding aggressive
[treatment] (i.e., resuscitation), but would not feel comfortable stopping treatment or transferring patient against
HCA's wishes.”

Physician responsibility at end of life
“As a physician one must limit suffering and inappropriate care at end of life;” “[Similar] patient died last year
after spending 10 months in the hospital, 8 of them in the ICU. On the day she died she wound up being coded
for 2 hours;”

“Her age, hemorrhagic stroke and dialysis make her chances of surviving a code very poor and this would seem
ineffective option for her. Also, the fact that she is on dialysis indicates an overall poor prognosis as does the
fact that she hasn't been successfully weaned off the ventilator. In her case, death does seem imminent, although
when this might happen seems to be uncertain. I would lean towards a comfort care approach, but if the
daughter insists on aggressive management, would probably get an ethics consult in this case.”

“Again, I have NO ethical objections to comfort care as it seems clear that this patient cannot live without fairly
substantial life support and that this is unlikely to change. In fact, she is likely to die with or without
continuation of aggressive care. However, until and unless the law is made more explicit in this regard, I would
be concerned over litigation. So, I would speak with Nephrology and see if they are comfortable withholding
dialysis and allowing her to die this way rather than actively taking her off vent.”

“To my knowledge it is close to impossible to transfer a patient to a chronic care facility if the HCPOA objects.
I personally would have been inclined to never offer dialysis stating that she has multiple organ failures and that
she is too weak for dialysis to help and that it might even make it harder to manage her infections and blood
pressure.”

“After consulting ethical advisory committee, I would stop the dialysis, continue vent, keep her in hospital for
4-7 days when she would die from uremia.”

“Would seek to continue current level of support but not advance intensity if expected/anticipated complications
ensue, including CPR which would indicate final event not a reversible one.”

General comments:

Ethics committee/palliative care
“I have a great working relationship with our palliative care staff. We have been very successful in limiting
inappropriate and futile care although sometimes it is quite a battle;”

“For all of the above vignettes and for this question: my experience with the ethics committee has been that we
can usually come to a "fair" agreement with the patients' decision makers that involves backing off from
maximal care. I have not yet had a situation where care that I have felt to be ineffective had to be withheld or withdrawn over the objections of a patient's decision maker. I have, on rare acute occasions, run a round of ACLS resuscitation that I knew would be ineffective, rather than create a family confrontation by withholding it against the decision maker's objections."

“The ethics committee has been very helpful in getting everyone involved in a case to see things from a broader perspective, to understand others' points of view, to get everyone on the same page in terms of the goals of care and importantly, in cases like the ones above, to determine what would be medically futile treatment. It also probably helps the family to know that it’s not just physicians that have thought about this decision, but also people from other walks of life who are a part of the ethics committee.”

“When we have gotten them [ethics committee] involved (two cases I can remember) they have been very helpful and encouraged comfort care and DNR. It just doesn't necessarily make a difference with the family. One case I had did and the other did not.”

“I'm on the ethics committee at our hospital, so I generally know what they (we) would recommend.”

“Our ethics committee has not been helpful in terminal cases. If I wanted to make the patient terminal due to medically ineffective therapy, the ethics committee has told me that I can't if the family disagrees.”

“Except the Ethics Committe never goes against the families wishes in my experience.”

“It is very difficult to set up an adversarial relationship even when you know it’s futile care. Unfortunately it’s easy for hospital ethics to say something is unindicated, but they are not actually writing the orders or taking on the ensuing adversarial relationship.”

“Ethics committee is advisory only and has no teeth.”

**Lack of institutional support**
We are at the mercy of the Office of General Counsel, who will stand by its interpretation of the law until the law is rewritten. Ethics Committee opinion has not been considered relevant to its interpretation and has these opinions have frequently contradicted each other.”

“I am board certified in IM/Pulm/CCM and Palliative Medicine. Yet, my willingness to discontinue futile care early on has brought me disagreements and problems with the rest of the medical staff who sometimes are hesitant to recruit my efforts for ICU care. This is a difficult and important issue to continue to educate ourselves and our fellow physicians.”

“I believe in oposit but do not have enough support from hospital and risk management.”

“The Ethics Committee only makes suggestions based on theory and this in no way protects the practicing physician from litigation. You will stand alone in court...the Ethics Committee won't be sued!”

**How to best support grieving families**
“Even when it is clear that therapy is futile or ineffective it is very difficult to withdraw or withhold life sustaining therapies when families are very adamant about doing "everything". Families can be very difficult beyond reason. Often times the family member of POA is really thinking of themselves and not the patient, likely subconsciously, when they refuse to change code status etc. Some family members have even told me that they know what the right thing to do is but that they cannot do it because they cannot bear the guilt and the aftermath from the rest of the family. Some families cannot let go and get very angry with the care team for
being too frank. In today's malpractice climate I think many docs find it the path of least resistance to acquiese to the family's wishes as long as they are somewhat reasonable, despite the ethical dilemmas. Many times we are not only treating the patient but the family as well.”

“Often we will continue after the ethics [committee] has said it is ethically appropriate to withdraw but I am looking to become educated as to how many of these cases generate a lawsuit -- More for hassle and emotional stress of facing one generated than for the fear of losing a lawsuit. There is not a culture of families knowing they will have to accept limits. I have told families after several "code blue" resuscitations of a terminally ill patient-- "OK we will not do this again" because of futility and belief that it is only causing suffering and have forced a DNR into the situation but I have never withdrawn a ventilator or antibiotics against a family's wishes. There are many times where this would have been appropriate, however.”
APPENDIX 1 – VIGNETTES

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 intubated and sent to the ICU. She remains non-communicative, very heavily ventilator dependent, and unable to be weaned. Tests show widespread cancer throughout the lungs, metastasized 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 it was unsuccessful. You believe that Mrs. H’s death is inevitable; although she can be kept alive somewhat longer on the ventilator, 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.

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 ICU for one month now. She is ventilator dependent and receives kidney dialysis. She is largely soporific, opening her eyes at times with a blank expression that 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 your 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. You have told the daughter that machines are keeping her mother alive. You strongly recommend 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.

Mr. W

Mr. W., a 25 year old man with pneumonia 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 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, members of the treatment team question the worth of continued treatment given his irreversible loss of consciousness.