Ethics and the ICU

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Introduction

Ethical issues continue to exist in the ICU and in many ways are becoming more complex. Despite years of bioethicists and increased attention to the challenging situations in the ICU, the issues do not get easier. As advances in technology increase in medicine and the application of this technology to prolong life, we deal with more and more ethical conundrums. As a society, we are increasingly independent and demand autonomy. As healthcare providers, we feel obligated to honor autonomy. As humans, we often want to avoid conflict, and it is easier to just "do everything" than take the time and energy to explain why that may not be beneficial to the patient. The purpose of this chapter is to review several ethical principles and situations common in the ICU and hopefully offer guidance and potential solutions.

Withdrawing and Withholding

One of the most important ethical principles is withdrawing/withholding potentially life-sustaining therapy (LST). Withdrawing LST is stopping therapy that has already been initiated (e.g., withdraw of mechanical ventilation, discontinuing dialysis). Withholding is not starting potentially LST (e.g., do not resuscitate/do not intubate DNR/DNI, not initiating dialysis). Legally and ethically, they are both equal; there is no moral difference between withdrawing a therapy and withholding a therapy. We tend to consider them different, and withdrawing therapy can often be more difficult emotionally on the patients, the family, and the healthcare providers; in which case, it is even more crucial than ever that we have the difficult conversation with the patient and the family and determine goals of care prior to initiating LST.

In the past, the term euthanasia has been used. Passive euthanasia was used to describe the withdrawing of LST. However, this term has fallen out of favor as the intent of withdrawing therapy was never to kill the patient, but rather to focus on comfort, recognition of limitations of specific therapies to extend life, and acknowledging wishes of patients and families regarding goals of care. Active euthanasia is death of the patient caused by an action of the healthcare provider with the intent of ending the life of the patient (giving paralytics at time of withdraw of mechanical ventilation; high-dose potassium given to cause cardiac arrest). In several European countries, active euthanasia is legal.

DNR

"Do not resuscitate" is a common order in the hospital setting. DNR creates limitations to LST and is considered a form of withholding medical therapy. It is important to realize that code status really should exist in only two forms: full code and DNR. Unfortunately, we often create conflict in the ICU by asking patient to choose from a long list of therapies. Do you want chest compressions, cardioversion, vasopressors, intubation, noninvasive ventilation, etc.? This laundry list of medical interventions can be very difficult for the patients and the families; as a result, they seem to choose "do everything" rather than have to understand and make a decision on each option. Perhaps it is better if we as healthcare professionals think about CPR in another way: we code dead people, we treat alive people. Therefore, CPR is performed when a patient has no pulse; vasopressors and cardioversion are used on patients with a pulse. These options should not be presented to patients as treatment along a spectrum, but rather what to do once the heart has stopped.

A term that is perhaps a better option and clearer in terms of patients defining their wishes is "Allow Natural Death (AND). Patients seem to understand that term as "not being hooked to machines" and it can be used to define goals of care. AND seems to eliminate much of the confusion that

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can occur with the "limited resuscitation" menu of options. Most importantly, a DNR order does not mean "Do Not Treat." DNR means that we do not try to restart a heart that has stopped. We continue to treat the patient with appropriate medical therapies and discuss options regarding further treatments.

Futility

Futility is a term that all understand, but few can define, thus creating much of the conflict and ethical issues in the ICU. One definition of futility is treatments successful in less than 10 % of the patients. Futility has also been dismissed as a term, since many treatments are physiologically beneficial, even if those treatments do not change outcome or restore the patient to health. An example would be dialysis in the dying patient in the ICU; the patient will still die, but dialysis does what it is designed to do, which is clean toxins and fluid from the body.

Healthcare professionals often consider many medical treatments in the ICU as futile, which we tend to define as "inability to survive outside of the ICU." The new term to describe these patients is "the hospital-dependent patient." For some families, the fact their loved one is alive is sufficient. The traditional "quality of life" argument often does not work in discussion with many families. Discussions of goals of care and ability for their loved one to participate in activities that are important to them are often a more beneficial conversation and may help families define the limits of treatment in the ICU. Another term that may be more helpful than "futile" is "non-beneficial treatment." We need to help the patient and family define non-beneficial in terms of what the patient would consider beneficial related to the context of their lives; again, a goal of care discussion is indicated. Several critical care organizations have composed a consensus statement regarding futility in the ICU, and they recommend the term "potentially inappropriate" rather than "futile."

Most importantly, healthcare professionals are not obligated to provide nonmedically beneficial treatment regardless of patient and family demands. Examples of this would include CPR in a patient with uncontrolled bleeding and an inability to stop the bleeding, liver transplant in stage 4 cancer, and surgical feeding tubes in advanced dementia. The Choosing Wisely campaign by the ABIM Foundation is meant to offer guidelines in nonmedically beneficial tests and treatments (www.choosingwisely.org). Autonomy is a negative right, not a positive right. Patients have the right to refuse medical treatments, even if it would save their life. Patients do not have the right to demand non-beneficial treatments.

Advance Directives/POLST

In an ideal world, everyone would write down his or her wishes for treatment near the end of life. These wishes would be clear, concise, and leave no scenario undefined, making ethical dilemmas rare. Regrettably, few of us ever write down our desires, and even less likely do we ever discuss them with our families. The lack of planning for the end of our lives has created a huge burden on families, healthcare providers, and the healthcare system. Despite an increased effort to encourage people to fill out an advance directive (AD), few do so. (Do you have one?).

One problem with AD is they tend to be vague. "If terminal or permanent unconsciousness" is often the clinical scenario included. In the ICU, very few patients are declared "terminal" or "permanently unconscious." Families and healthcare providers are then tasked with trying to define what exactly the person wanted in this particular clinical situation. Including families in the discussion in the creation of the advance directive is critical to its implementation. Physicians tend to preferentially honor family requests over what is written on the patient's AD, therefore making it crucial for the family to be involved in the advance directive discussion. Several states are considering legislating advance directives over surrogate decision making, potentially resolving some of this conflict. However, given the generic nature of AD, discussion regarding treatment options with family is still necessary.

One potential solution to the AD is the use of physician orders for life-sustaining therapy (POLST, www.polst.org). POLST has been adopted by many states and has several variations on the name (MOLST, POST). The goal is the same: to define goals of care in patients with a terminal condition. POLST is generally on a bright pink card stock, designed to be immediately visible to EMS and healthcare providers. POLST defines treatment in terms of full treatment, limited treatment, or comfort care as the goal. POSLT also includes options for antibiotic use, DNR, artificial nutrition and hydration. These are actual healthcare provider orders that cross the spectrum of healthcare settings, preventing multiple DNR discussions as the patient is, for example, transferred to the hospital from the nursing home or from home to the hospital. If the patient signs POLST, it cannot be overruled or changed by the surrogate decision maker. The patient can change their mind and void the orders. If a member of the family signs the POLST form, the signer can change the orders. There are legal protections for healthcare providers for honoring a POLST. The major limitation of POLST is that the patient must be terminal (usually stage 4 cancer, advanced dementia, end-stage COPD, or CHF).

Artificial Nutrition and Hydration

Nutrition and early use of enteral feedings has made a huge difference in the outcomes of patients in the ICU. There are few ethical issues regarding the use of enteral feeds in the ICU. The controversy arises in the placement of surgical feeding tubes (PEG or gastrostomy tube) in select patient populations. As the population ages and dementia becomes more common, many of these patients come to the ICU for treatment of injuries from falls, sepsis, pneumonia, etc. Their swallowing difficulties become quickly apparent and often trigger a series of events resulting in a speech therapy evaluation which documents the dysphagia, then a consult for PEG tube placement. Often this medical pathway takes on a life of its own and occurs without a discussion of goals of care and whether artificial nutrition and hydration are beneficial in these patients in changing survival. Both the American Academy of Hospice and Palliative Medicine (AAHPM) and the American Geriatrics Society (AGS) have position statements on ANH in advanced dementia. Generally, the recommendation is not to offer feeding tubes to these patients. Since this pathway often begins in the ICU, we need to be aware of the need to start discussions early with the families.

Dialysis

Dialysis in the ICU can be lifesaving, especially in cases of drug overdose or rhabdomyolysis. Dialysis can be less helpful in cases of multisystem organ failure or the very elderly. As it is a technology that we have, we often have difficulty limiting offering it to patients. The nephrology literature has begun to recommend that nephrologists be involved with the goals of care discussions with patients and their families prior to initiating dialysis. The literature also makes specific recommendations for decision making and conflict resolution in cases of dialysis.

One strong recommendation from the ethics literature and palliative medicine literature is to consider time-limited trials. Although the best option may be not to initiate therapies that may not be beneficial and with the difficulty of stopping treatments, one consideration is to offer a time-limited trial. Offering a therapy to a patient for a limited period of time (usually 72 h) to see if improvement occurs is one way to help the patient and the family as they wrestle with options regarding care. Time-limited trails offer an opportunity to see if the treatment is beneficial without the commitment of indefinite continuation. When the trial is over and no improvement is seen, the treatment stops automatically. A time trial allows more time for ongoing discussions regarding goals of care and a plan for withdrawal of therapy that is often easier emotionally on the family and the healthcare team.

Organ Donation

The goal of organ transplantation to save lives is an admirable goal. The ICU is often involved in the care of potential organ donors. As the technology increases to preserve organ function until donation can occur, ethical issues seem to be increasing rather than decreasing. One ethical issue regarding organ donation is driver's license assent; checking the box "yes" (or in some states "no" is not an option, only "skip the question") is considered first person consent for organ donation and by federal law overrides the family wishes if they do not want to donate. The issue of "opt-out" vs. "opt-in" is currently being debated in the literature, but more and more states are going to an "opt-out" model, meaning the default is the patient is an organ donor unless explicitly written somewhere, usually in an AD.

Another ethical issue regarding organ donation is organ preservation protocols. Prior to the patient being considered for organ donation, or being declared dead by neurological criteria (brain death), a variety of procedures and treatments are given not for the benefit of the patient but for the preservation of the organs. These treatments can include resuscitative thoracotomies to restore circulation for organ retrieval in the trauma bay, hormonal therapy to preserve organ function, placement of lines, use of vasopressors, transfusions, and several others. In some hospitals, these protocols are the default for all patients who are potential organ donor candidates, potentially shifting the focus from caring for the patient to caring for his organs.

In order to increase the donor pool for solid organ transplantation, death by neurological criteria (brain death) is not the only option. Many hospitals are performing donation by circulatory death (DCD), where the withdrawal of LST occurs in the operating room and organ retrieval occurs once the patient progresses to cardiac standstill. DCD continues to be controversial in the ICU and the ethics literature.

Ethics Consultation, Palliative Medicine, and Conflict Resolution

Most hospitals have an ethics consultation service that often involves a single provider obtaining the necessary information and the ethical issue at hand and speaking to the family, healthcare team, and patient if possible. The ethical issues will then be presented to an ethics committee that tends to be multidisciplinary (social worker, chaplain, physician, nurse, administration, and others). They will discuss the case, discuss the ethical principles involved, and often write a recommendation regarding what is ethically permissible in this particular case. Focusing on what is ethically permissible rather than providing a direct solution to the ethical issue can be frustrating for everyone involved hoping for an answer. Standards regarding ethic consultations have been developed, and it is recommended that the team leader have a master's degree in ethics.

Given the limitations of ethics consultation, many hospitals have asked the palliative medicine service to assist with these ethical issues. Many of the ethical dilemmas in the ICU arise from application of medical technologies that may not be beneficial for the patient. In a busy ICU, it can be very difficult to take the time necessary to explain all options to the family and to put these technologies into perspective regarding the patient's wishes. These discussions are often called "goals of care" discussions. A palliative care team consisting of a physician, nurse practitioner, social worker, chaplain, and potentially other members can often help the families walk through the process of this decision-making process. Some have suggested that including palliative medicine as part of the ICU multidisciplinary team may improve the outcomes and experiences for patients and the families, as well as avoiding much of the conflict that can occur in the ICU.

Since many hospitals and ICUs have not integrated palliative medicine into the ICU team, and we tend not to be proactive in preventing conflict, a conflict resolution team has been suggested as the next step for dealing with the unresolved conflict in the ICU. The primary goal of this mediation is to actually mediate the conflict; they do not have a vested interest in the outcome, just that an outcome suitable to all can be reached. There are two methods of conflict resolution: one in which the mediator reads the chart, talks to the healthcare providers, and gathers information before meeting with all parties involved. The second method involves the mediator coming to the table with the interested parties (usually family and the ICU team) and listens to the issues at the time. The mediator can then choose to interact with individuals or small groups of the people involved before helping all come to a consensus. This process tends to be very labor intensive and time consuming, not only for the mediator but also for the ICU team. Given the extensive time commitment required for conflict mediation to be successful, it is often not a technique that is utilized. However, it can be a great resource for the ICU team and families when an impasse in the ICU is reached.

Conclusion

In an ideal world, the patient will have an advance directive, POLST orders if appropriate, a family who is in complete agreement with the wishes of their loved one, and a clearly communicating and realistic ICU team regarding the benefits and limitations of the ICU. Communication can solve many of these ethical dilemmas, but we also have a responsibility to recognize that increasing use and development of technology creates new challenges and can sometimes solve existing ones. General recommendations for prevention of ethical dilemmas in the ICU, which usually are conflict with the family, are early, and frequent communication, a consistent message from the ICU team, goals of care discussions, integration of palliative medicine in the ICU, and conflict resolution/mediation as needed.

Suggested Reading

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