End Of Life Decision Making - Who’s Decision Is It Anyway?

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End-Of-Life Decision Making

- Twenty percent of deaths follow admission to the ICU
- Often associated with decisions to forego life support or withdraw from life support
- End-of-Life Decision Making has become a key feature of critical care practice
End-Of-Life Decision Making

• Literature and practice experience tells us that there can be shortcomings in end-of-life care in the ICU
• Patients unlikely to benefit are admitted frequently leading to needless suffering and wasted resources
• Inadequate treatment of pain and dyspnea can occur*
• Patients’ relatives frequently develop psychiatric morbidity which has been suggested to be partly related to conflict with physicians and stress connected with end-of-life decisions
End-Of-Life Decision Making

• End-of-life care varies dramatically among physicians, hospitals, and countries fueling concern that factors besides a patient’s illness and preferences drive treatment decisions.
• In one Canadian study (Cook 1995), clinicians shown identical hypothetical cases suggested widely different treatments ranging from aggressive care to palliation.
• Other studies have shown widely varying rates of decisions to forego life support, use of DNR orders and willingness to treat patients who are permanently unconscious or terminally ill.
• Why variability occurs is unknown but likely due to differences in practice style, access to care, & local cultural and religious traditions.
End-Of-Life Decision Making

- ICU management and care clearly improves survival for appropriately targeted patients
- Careful decision making is essential to ensure that care provided is consistent with patients’ wishes
- Given their expertise, ICU practitioners are well positioned to provide outstanding end-of-life care and promote family satisfaction
Approach to End-Of-Life Decision Making

• The goal of End-Of-Life decision making is to meet patients’ wishes and needs, by choosing appropriate treatments
• In Western society, these choices occur within an ethical framework dominated by key precepts:
  – Respect for patient Autonomy
  – The practitioners duty toward beneficence and nonmaleficence
  – An obligation to ensure just distribution of resources
Approach to End-Of-Life Decision Making

- These precepts sometimes pose internal conflicts
- Patients may refuse treatment or request care physicians believe non-beneficial
- Alternatively, desired care may be unavailable, for example, if a shortage exists in ICU beds
- Respect for autonomy generally allows patients to refuse recommended care, although most agree that it does not require that physicians offer nonstandard interventions or care they believe harmful
Surrogate Decision Making

• Surrogates face special challenges particularly when patients’ wishes are often unknown

• A hierarchy for surrogate decision making is often utilized:
  – First, surrogates are asked to report the patient’s specific preferences if known
  – Second, if this is not possible, surrogates are then asked to attempt substituted judgment, relying on available evidence to express what they believe the patient would choose if able
  – Finally, if preferences are not known, surrogates are often expected to choose the treatment they believe to be in the patient’s best interest
Surrogate Decision Making

• But how is a surrogate decision-maker trained to know what is in the patient’s best interest?
• Is it instead not the responsibility of the medical team to determine the interventions that will provide the highest likelihood of benefit?
• Decisions are made on a daily basis by medical professionals regarding the medical and surgical risk/benefits of treating every medical condition, so why relinquish this most delicate and irreversible decision to uninformed and nonprofessional individuals who bear the responsibility of this decision for the rest of their lives?
Surrogate Decision Making

• Have we not just imposed burden on lay individuals to make decisions for which they are not equipped to do so to lessen our burden of responsibility?
• Surrogate decision makers face enormous pressures
• Family members experience anxiety, depression, and features of post-traumatic stress disorder (PTSD)
• Participation in end-of-life decisions may contribute to psychiatric morbidity although further work is needed to confirm this finding and to identify the mechanisms involved
Surrogate Decision Making

- Many families report significant burdens placed on them when treatment decisions are made.
- According to families, helpful physician and nursing behaviours include:
  - Timely communication
  - Clarification of the family’s role
  - Facilitating family consensus
  - Accommodating grief
Surrogate Decision Making

• In contrast, unhelpful behaviours include:
  – Postponing End-of-Life discussions
  – Placing the decision-making burden on one person
  – Withdrawing from the family
  – Defining death as a failure

**Often, families state the burden of decision-making may be lessened if physicians take a more active role**
So why make family members choose the treatment they believe to be in the patient’s best interest, when they have clearly described the burden this causes and have asked for more physician input?
Proposal For a New Hierarchy For Surrogate Decision Making

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– Third, if preferences are not known despite thorough discussions with family members…
Proposal For a New Hierarchy For Surrogate Decision Making

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the physician will participate in shared decision making and determine which treatment options maintain their duty toward beneficence and nonmaleficence of the patient
Making Decisions – Family Discussions

• Agreement regarding treatment goals sets the stage for specific decisions
• A clear identification of goals followed by an assessment of whether they can be achieved should help families and caregivers choose appropriate treatments
• Goals can be grouped into 3 categories
  – To cure or ameliorate the patient’s illness using all available therapies without imposing limitations
  – To attempt disease treatment while limiting those interventions and treatments considered overly burdensome
  – To emphasize symptom management sometimes to the point of comfort measures only
Making Decisions

• Non treatment goals should include outcomes expressed in nonmedical terms such as a wish for the patient to return home, avoid disability or be free of pain
• Once goals are established, decisions regarding specific interventions should follow logically
• For example, if the decision is made to treat without limitations, it generally follows that all necessary interventions will be provided, including CPR, mechanical ventilation or dialysis
• In contrast, if comfort measures are emphasized, these interventions would make little sense
Making Decisions

- A more nuanced discussion may be necessary if the decision is to provide limited treatment
- Plans should be internally logical, recognizing that individual treatment decisions are not inherently independent
- For example, it would be inappropriate to provide CPR to a patient who arrests after foregoing intubation for respiratory failure
- Treatment decisions should be explicit and consistent with treatment goals
- All family members should have a clear understanding of the treatment goals and interventions that will or will not occur
Canadian Association of Critical Care Nurses

Trying Out Our New Hierarchy for Decision Making
Case #1 - Jessie

70 yo male arrives via EMS to your emergency department with a history of increasing shortness of breath, fatigue, fever, and cough with thick yellow sputum. He is found to be febrile, have an elevated WBC, and CXR reveals RLL pneumonia. His saturations are dropping and a decision needs to be made regarding his oxygenation and ventilation management. His past medical history includes COPD requiring home oxygen at 4lpm. He lives with his wife but performs all his own ADLs. He continues to have his driver’s license and uses the grocery chart to walk in the shopping mall. He has never been intubated or in the ICU before today.
85 yo female arrives via private vehicle to your emergency department with a history of nausea, vomiting, and abdominal pain. She is found to be febrile, have an elevated WBC, and an elevated lipase. She is diagnosed with pancreatitis due to her history of gall stones. While waiting for further diagnostic testing, she becomes very hypotensive, had a decreased LOC and is becoming profoundly septic. Her past medical history includes mild COPD for which she uses a ventolin inhaler prn. She is widowed and lives by herself in her home in North Edmonton. She has one son in Edmonton and another in Vancouver.
Case # 3 - Mary

52 yo female arrives via EMS to your emergency department with a history of sudden decreased level of consciousness. She has had a debilitating stroke 7 years ago at the age of 45yo and has lived in a nursing home ever since. The paramedic on seen intubated Mary due to a GCS<6 and for airway control as she was obstructing her airway. She is now in the ICU for mechanical ventilation and CT shows another large CVA. Mary is divorced and her daughter has just arrived in the ICU.
Case # 4- Max

28 yo male mechanic suffered severe trauma while at work when a car jack shifted and a large minivan fell on top of him while he was under it. He suffered a severe pelvis #, bilateral # femurs, multiple bilateral rib # with bilateral hemo/pneumothorax. He also suffered a SDH. He is in your ICU, is intubated and ventilated. His mother arrives for her first visit since his accident.
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He suddenly goes into a PEA cardiac arrest. He receives CPR for 15 minutes prior to spontaneous return of circulation. CT demonstrates large bilateral PEs and significant cerebral edema.