Medical Ethics/DPOA and End of Life Decisions

JON BEAULAC DO, FACOI

SERVICE LINE MEDICAL DIRECTOR OF MEDICAL SUBSPECIALTIES

MUNSON HEALTH

AGENDA

- Medical Ethics Principles
- When do we use advocates?
- What types of advocates are there?
- How does one obtain an advocate?
- Breaking Bad News/Code Status Discussion
- Advocate Case Scenarios
- Concerns about advocates/Ethics issues?
- Advance Directives vs. Living Will?
- What if a patient is underrepresented?

Define Ethics

- Philosophical study of moral behavior and moral decision making
- An approach to understanding, analyzing and distinguishing matters of right and wrong, good and bad, admirable and dishonorable as they relate to well-being and relationships.
- Involves the study of the process of moral deliberation and justification
- Activity that studies how choices were made or should be made

The Four Topics Chart (Jonsen, Siegler, Winslade)

MEDICAL INDICATIONS

The Principles of Beneficence and Nonmaleficence

1. What is the patient's medical problem? History? Diagnosis? Prognosis?
2. Is the problem acute? Chronic? Critical? Emergent? Reversible?
3. What are the goals of treatment?
4. What are the probabilities of success?
5. What are the plans in case of therapeutic failure?
6. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?

PATIENT PREFERENCES

The Principle of Respect for Autonomy

1. Is the patient mentally capable and legally competent? Is there evidence of incapacity?
2. If competent, what is the patient stating about preferences for treatment?
3. Has the patient been informed of benefits and risks, understood this information, and given consent?
4. If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making?
5. Has the patient expressed prior preferences, e.g., Advance Directives?
6. Is the patient unwilling or unable to cooperate with medical treatment? If so why?
   In sum, is the patient's right to choose being respected to the extent possible in ethics and law?

QUALITY OF LIFE

The Principles of Beneficence and Nonmaleficence and Respect for Autonomy

1. What are the prospects, with or without treatment, for a return to normal life?
2. What physical, mental and social deficits is the patient likely to experience if treatment succeeds?
3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life?
4. Is the patient's present or future condition such that his or her continued life might be judged undesirable?
5. Is there any plan and rationale to forgo treatment?
6. Are there plans for comfort and palliative care?

CONTEXTUAL FEATURES

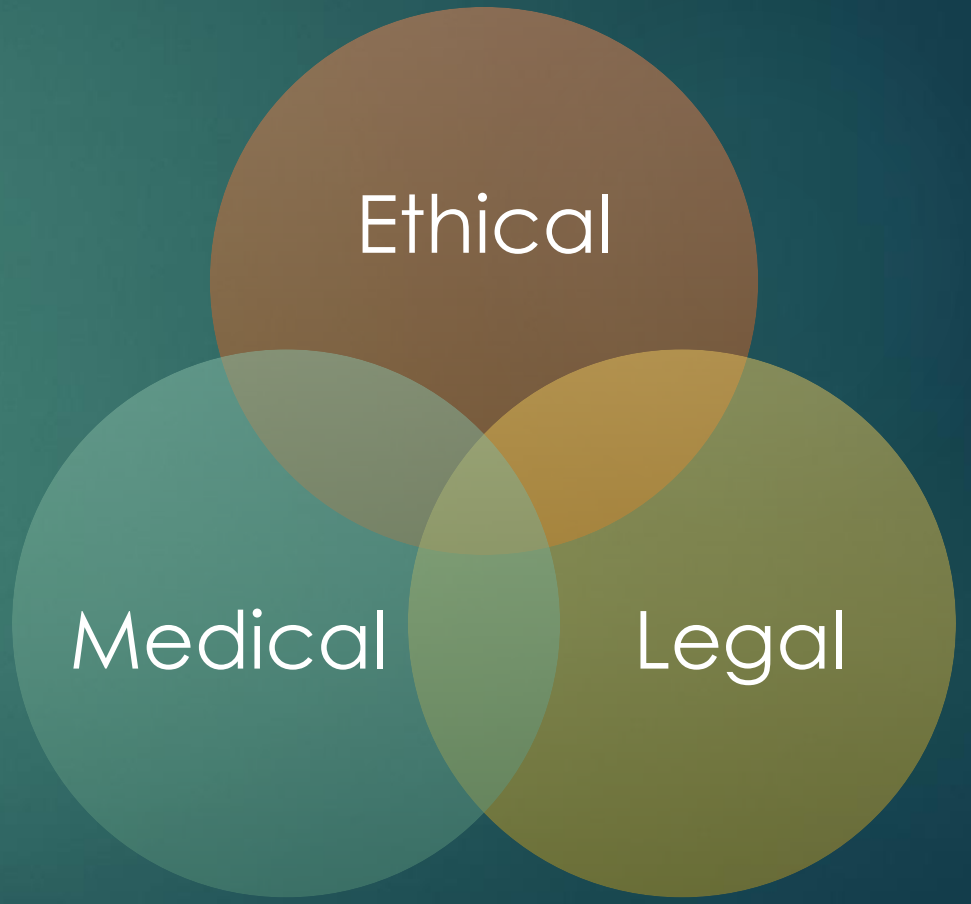
The Principles of Loyalty and Fairness

1. Are there family issues that might influence treatment decisions?
2. Are there provider (physicians and nurses) issues that might influence treatment decisions?
3. Are there financial and economic factors?
4. Are there religious or cultural factors?
5. Are there limits on confidentiality?
6. Are there problems of allocation of resources?
7. How does the law affect treatment decisions?
8. Is clinical research or teaching involved?
9. Is there any conflict of interest on the part of the providers or the institution?

Relationship of Ethical and Legal Issues with Medicine

Examples:

- Medical/Ethical- when is it ok to withdraw ventilator care?
- Ethical/Legal – who gets to make the decision to withdraw medical care?
- Medical/Ethical/Legal – why would we seek a guardian to make medical decisions for a patient?



Principle of Proportionality

- Balances the intended benefits of treatments against the possible burdens
- A medical treatment is ethically mandatory to the extent that it is likely to confer greater benefits than burdens
- To recommend or provide
- Premise that ‘no absolute duty to preserve life exists’
- Patient’s view of quality of life

Principle of Double Effect

- To perform an act with good conscience when an act has both beneficial and harmful consequences.
- If you do something morally good (positive intent) and it has a bad side effect—*ethically,* it is okay to do it -- providing the bad side effect wasn't intended.
- Example: administration of comfort medications

Advocacy

- The noun *advocacy* comes to English from a term used in Roman law. An advocate was a professional whose job was to plead cases in front of a court of law. That meaning led to the verb form *advocate*, as well as *advocacy*, to describe the work of an advocate. -Vocabulary.com

When do we use advocates?

- -Patient is incapacitated or has been deemed incompetent in the eyes of the court.
- -Complex medical decisions
- -Emotional support
- -Patient may have capacity but has some limits to cognition and requests assistance/presence of advocate.

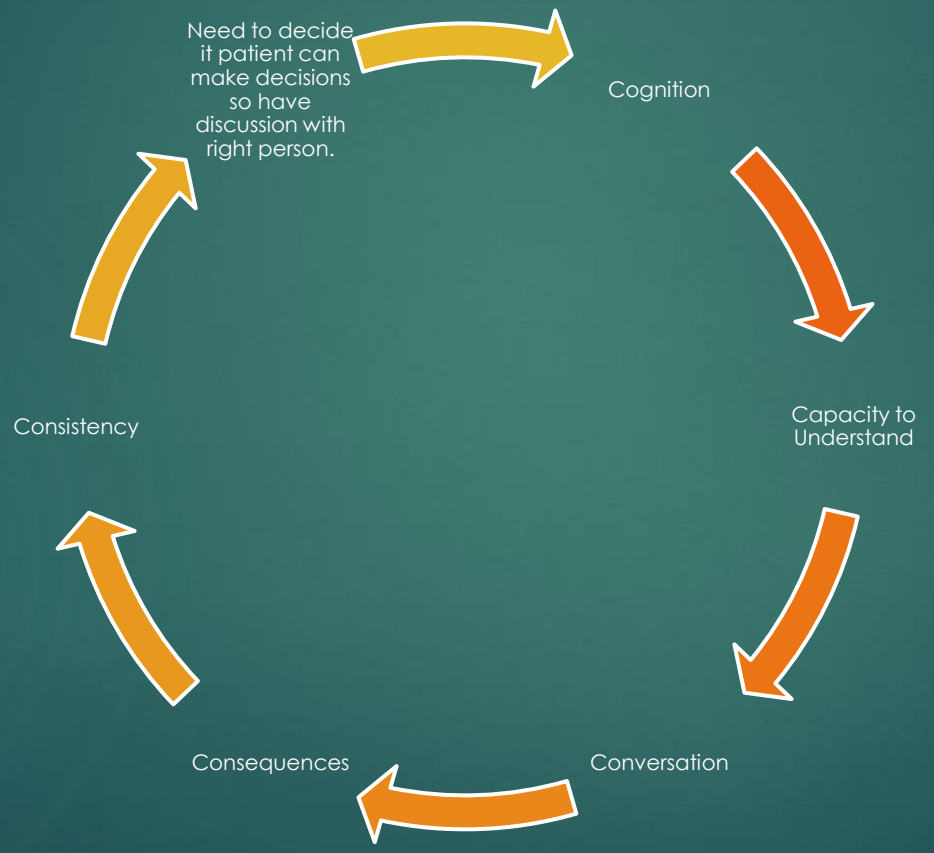
- How do we assess capacity? Miller and Marin Algorithm for Decision Making Capacity

Advance Directives

Ethical Guidelines for Advance Directives

- Decision-makers base decisions on what the patient would have decided if they were able
- Cannot override decisions already made by the patient while still able to decide for themselves
- Cannot require a physician to provide treatment that is not medically beneficial but **may refuse treatment that is considered a benefit**
- Medical benefit or appropriateness of an intervention is based upon medical reasons, should not be based on the patient's religious or cultural views

Determining Decision Making Capacity (5Cs)



TYPES OF ADVOCATES

Next of kin
Verbal decision maker
DPOA-HC/Advocate
DPOA-Financial
Executor
Guardian
Petition for probate
MI-POST

Know difference between living will and advance directives

Medical Durable Power of Attorney

- Personal Choice
- Usually attached to Advanced Directive
- Often more useful than Advanced Directive alone
- Not a Living Will
- If patient too confused to complete, then need guardianship if no clear decision maker in family

Patient is Incapacitated and No Formal Decision Maker Present

Next-of-Kin (Michigan)

1. Spouse
2. Adult Children
3. One/Both Parents
4. Siblings
5. Nieces/Nephews

If discrepancies, majority rules, may lead to pursing guardian.

Underrepresented patients

- What if there are no decision makers? No advocate? No Next of kin? What if just a neighbor is listed in emergency contact?
- Ethics consult→ Underrepresented persons policy? Do you have a policy?

Issues with advocates

- Patient advocate forms such as DPOA typically have value statements about care preferences.
- What if advocates are not following the outlined care preferences?
- What if preferences are broad or there are none and advocates are requesting therapies that are not considered to be medically beneficial?
- What if the advocate is not acting in the best interest of the patient inside or outside of the hospital?
  - Financial/Physical/Emotional/Sexual Abuse or Neglect (being left unsupervised in a compromised state)
  - Asking for unreasonable care?
  - Becoming an obstruction to care? Preventing pain medication?

Scenarios

- Scenarios:
  - What if a patient already has a guardian? Patient refusing care?
  - Court appointed guardian? Do we call family or guardian?
  - Incarcerated patient, do we call family?
  - Patient has been made incapacitated… can they still make some decisions and assign a surrogate????!
  - Does the patient have to stay in the hospital if they are incapacitated and do not have an advocate?

Making Wishes Known

- Advance directives
- Living Will
- Verbal statements prior vs. current
- Are those wishes reasonable? Does the patient know fully what they are wishing for?
- Role of educating on CPR (fully informed consent)?
- Avoid jargon.
- Avoid phrasing: Want us to do everything? Want us to stop care?

What do patients want?

- Patient Preferences Regarding CPR Influence of Survival Probability

	Acute Illness	Chronic Illness
Estimated probability of surviving CPR	26% +/- 22	15% +/- 16
Preferred CPR before knowing probability	41%	11%
Preferred CPR after learning survival probability	22%	5%
> 85 years old	6%	3%

-42% would want CPR if < 50% chance of leaving hospital

-25% would not want CPR if 100% chance of leaving hospital

Murphy et al NEJM 1994

CPR Survival in the Hospital Setting

- National Registry of CPR - 20 min. after CPR survival 44%, only 17% of all CPR patients survived to discharge
- Meta Analysis – 1998 - Factors predicting a failure to survive to discharge include:
  - Sepsis one day prior to CPR event
  - Serum Cr > 1.5 mg/dl
  - Mets Cancer – (2-6% survived to discharge)
  - Dementia
  - Dependent status
- Dialysis pts -14% survival to discharge
- On average overall – 15% (1 in 6) may survive to discharge, worse survival with increased co-morbidities and/or CPR related complications

Treatment Geared For Recovery

- What is meant by recovery?
  - Live at any cost?
  - Live to leave hospital only to return again soon?
  - Must be compared with goals for care
  - Can there be a recovery? If not can we make life a little better?
- What happens after treatment?
- Home care
- Nursing home
- Adult Foster Care
- Return home? Enough support?

More options

- Time-limited trials –"give it a try"
  - See if an intervention helps or hurts
  - "one more hospitalization"
  - One more chemotherapy cycle
  - Blood products, labs, etc
  - PEG

HOPE

- If time limited trials don't work, there is always a back up plan:
- Hospice and palliative care is about HOPE:
  - Hope is an expectation greater than zero of achieving a goal
  - Hope is an orientation of the Spirit, and orientation of the Heart.
  - Sometimes focus of hope changes with conditions.
  - Hope is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out.
    - Example: Hope to be at peace and comfort with family at end of life.

How To Break Bad News

When Outcomes/results are not as hoped or expected:

Keep in mind:

- Participants
- Timing
- Location
- Fact-gathering
  - What they know
  - What they want to know
  - Cultural or religious issues
- Review information – Allow for uncertainty
- Assure continuation of care

6-step protocol . . .

1. Getting started
2. What does the beneficiary know?
3. How much does the beneficiary want to know?

Adapted from Robert Buckman

. . . 6-step protocol

4. Sharing the information
5. Responding to beneficiary, family feelings
6. Planning and follow-up

Adapted from Robert Buckman

Step 1: Getting started . . .

- Get the right people present – may need to find out who beneficiary wants present
- Plan what you will say
  - confirm medical facts
  - don’t delegate
- Create a conducive environment
- Allot adequate time
- Reschedule if not prepared.

Step 2: What does the beneficiary/representative know?

- Establish what the beneficiary knows or what family/representative knows
  - **What do you understand about current medical condition**
- Assess ability to comprehend new bad news
- May need to ask beneficiary how much they want to know or if they want you to talk to representative.

. . . Step 3: How much does the beneficiary want to know?

- People handle information differently
  - race, ethnicity, culture, religion, socioeconomic status
  - age and developmental level

Step 4: Sharing the information . . .

- Say it, then stop
  - avoid monologue, promote dialogue
  - avoid jargon, euphemisms
  - pause frequently
  - check for understanding
  - use silence, body language

. . . Step 4: Sharing the information

- Don’ t minimize severity
  - avoid vagueness, confusion
- Implications of “I’ m sorry”
  - Ok to say
  - You are empathizing with situation not apologizing for making error.

. . . Step 5: Responding to feelings

- Listen quietly, attentively
- Encourage descriptions of feelings
- Use nonverbal communication

Step 6: Planning, follow-up . . .

- Plan for the next steps
  - additional information, tests
  - treat symptoms, referrals as needed
  - When you will call/visit again
  - Who is best contact from family but also best contact for treatment team
- Discuss potential sources of support

. . . Step 6: Planning, follow-up

- Before leaving, assess:
  - safety of the patient
  - supports at home
  - Can discuss DC plan if patient does improve
    - Good thing for families to think about as most seriously ill patients wont be able to go home and this is often goal for patient.
- Repeat news at future visits

Expression of Wishes in Response to Loss, Futility and Unrealistic Hope

- Avoid hopeful statements unless there is a reasonable chance of success.

- Statements of wishes can:
  - Acknowledge limited control over a situation by a physician
  - Express regret that more can not be done.
  - Allow clinician to enter patient's world.
  - Result in deeper level of conversation.
  - Humanizes the medical encounter

Quill et al *Ann Int Med 2001*

Expression of Wishes in Response to Loss, Futility and Unrealistic Hope

Clinical Scenario	Sample Response
Delivering very bad news	I wish I had better news to give you
Responding to unrealistic hopes From a patient or family	I wish that were possible. It sounds like all of us would be would be a lot happier if that were so.
Responding to demands for Aggressive treatment when Prognosis is very poor	It must be very hard to come to the intensive care unit every day and see so little change. I wish medicine had the power to turn things around
Responding to expressions of Loss, grief, and hopelessness	It sounds like a terrible loss for you. I wish it hadn't turned out this way.

Quill et al. *Ann Int Med* 2001

MI-POST Michigan **P**hysician **O**rders for **S**cope of **T**reatment

- Code status and may list other preferences
- Describes wishes for health care in a medical emergency
- To be legally valid must be signed by patient/DPOA/guardian and qualified healthcare provider: licensed physician, nurse practitioner or physician assistant
- Still advised to have DPOA-HC
- Brightly **colored pink paper** and follows a pt through multiple healthcare settings: hospital, nursing home, EMS
- MI-POST (michigan.gov)

MI-POST

MDHHS-5836, MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST)

Michigan Department of Health and Human Services (MDHHS)
(Revised 8-22)

HIPAA permits disclosure of MI-POST to other Health Care Professionals, as necessary. This MI-POST form is void if Part 1 or Section D are blank. Leaving blank any section of the medical orders (Sections A, B, or C) does not void the form and is interpreted as full treatment for that section.

PART 1 – PATIENT INFORMATION

Patient Last Name	Patient First Name	Patient Middle Initial

Date of Birth (mm/dd/yyyy)	Date Form Prepared (mm/dd/yyyy)

Diagnosis supporting use of MI-POST

This form is a Physician Order sheet based on the medical conditions and decisions of the person identified on this form. Paper copies, facsimiles, and digital images are valid and should be followed as if an original copy. This form is for adults with an advanced illness. It is not for healthy adults.

PART 2 – MEDICAL ORDERS

Section A – Cardiopulmonary Resuscitation (CPR)

Person has no pulse and is not breathing. See MDHHS-5837 for further details.

- ☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
- ☐ DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).

Section B – Medical Interventions

Person has pulse and/or is breathing. See MDHHS-5837 for further details on medical interventions.

- ☐ **Comfort-Focused Treatment**
  Primary goal of maximizing comfort. May include pain relief through use of medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance.
- ☐ **Selective Treatment**
  Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac monitoring including cardioversion, and non-invasive airway support.
- ☐ **Full Treatment**
  Primary goal of prolonging life by all medically effective means. May include intubation, advanced invasive airway interventions, mechanical ventilation, other advanced interventions.

Section C – Additional Orders (optional)

Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may

3 Functions of Healthcare Ethics Committees

HEC

1.) Consult on difficult clinical decisions

2.) Formulating institutional policies (consistent with the organization's function and mission)

3.) Education hospital personnel about policies and healthcare ethics in general

Ethics consultants or committee do not make final decisions or write orders. It is up to the attending physician and the patient to accept or reject the recommendations.

THANK YOU

QUESTIONS?