Ethics and End of life Care in the intensive care unit

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Foundations of Critical Care Course
THE PROBLEM WITH ETHICS?
LEARNING OUTCOMES:

• - Have an understanding of the theories and principles used to frame discussions of ethics.
• - Have an awareness of how those theories and principles might be applied as medical ethics in the intensive care setting.
Ethical Principles and Theories

• Each Ethical theory emphasises different points to achieve an ethically correct decision

• Ethical principles are essential for a theory to be useful. These are common goals each theory tries to achieve. Most commonly used in medical ethics are Beauchamp and Childress.
Beauchamp & Childress: principlism

– Widely used framework.

– Provides a ‘common language’ for inter-professional discussion.

– Four Principles provide a flexible guide that leaves scope for interpretation in specific circumstances.
ETHICAL PRINCIPLES IN HEALTHCARE

• AUTONOMY:
  • SELF-RULE – the right of competent adults to make informed decisions about their care.
  • Dependent on liberty & agency.

• NON-MALEFICENCE:
  • DO NO HARM
  • Risk of harm should not be disproportionate to the benefit.
ETHICAL PRINCIPLES IN HEALTHCARE

• BENIFICENCE:
  • DO GOOD.
  
  • POSITIVE BENIFICENCE: To act for the benefit of others.
  
  • UTILITY: Balancing of benefits & risks to produce best overall result.

• JUSTICE:
  • Fair, equitable & appropriate treatment.
  
  • Distributive Justice:
Autonomy & consent in intensive care
Mental Capacity Act

Principles

• You must assume a person has mental capacity unless it is established they don’t

• A person is not to be treated as though they cannot make a decision unless all practical steps have been taken to help them do so without success

• A person is not treated as unable to make a decision merely because they have made an unwise decision
Mental capacity act (2005)

PRINCIPLES:

• The treatment of adults without capacity must be done in their best interest.

• Allows patients to record their future healthcare wishes in the form of a person (Lasting Power of Attorney) or in writing (Advanced Directive).
Mental capacity act 2005

• **Lasting Power of Attorney: (LPA)**
  - May be granted by a competent person who predicts future incompetence.
  - Recognised as surrogate or proxy decision maker.

• **Advanced Directive:**
  - Competent & informed person acting voluntarily
  - Describes what specific treatment are refused/requested & in what specific circumstances.
Two stage test for mental capacity

1. Ask yourself, does this person have an impairment or disturbance of the functioning of the mind or brain?

   • Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?
Two stage test for mental capacity

2. If so a person is unable to make specific decision for themselves if they are unable to
   • *Understand* information about the decision
   • *Retain* the information
   • *Use* information to make a decision and assess risks
   • *Communicate* their decision
Autonomy & consent in intensive care?

Where Capacity is found to be Lacking:

- Promote autonomy by investigating and seeking evidence of what their wishes might have been in their current situation.

- Must take appropriate actions to help patient demonstrate capacity where able.
Role of family

• In the absence of evidence of patient’s likely wishes the clinician will determine treatment based on an evaluation of the patient’s **best interest**.

  • Family/carers/NOK must be consulted
  • Decision lies with the decision maker ie: Dr

  • Think IMCA
  • Court of protection
Emergency situations

If patient lacks capacity
• Act in best interests if decision needs to be made urgently
• Must be the least restrictive option
• Capacity must be reassessed
• Consult family/carer/advocate as necessary
Restraint

• **Capacity must be assessed**
  • Should be seen as last resort
  • Only permitted if person using believes it is necessary to prevent harm to an incapacitated person
  • Require urgent life saving treatment
  • Should be proportionate to the likelihood and severity of harm
    • Least restrictive
  • **Documentation?**
DEPRIVATION OF LIBERTY SAFEGUARDS (2009)

Allows restraints and restrictions to be used in the patient’s ‘best interest’ in hospitals or care homes where patients lack capacity to consent.

What constitutes a restraint or restriction?

When is DOLS justified?
• In patient’s best interest
• Proportional response to the potential harm
• No less restrictive alternative
Ferreira Judgment 2017

• The Court of Appeal (in *Ferreira v Coroner of Inner South London*, 26 January 2017, per Lady Justice Arden) is clear that “…any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1)

• https://ics152.files.wordpress.com/2017/01/ics-ficm-guidance-on-mca-and-dol.pdf
Summary

• Ethics provide useful framework for complex clinical situations and decisions, especially where no clear correct answer exists.

• MCA and DOLS provide legal framework for both routine and emergency situations in critical care.
End of Life Care/Bereavement

“How people die remains in the memory of those who live on”

by Dame Cicely Saunders
• The challenges of end of life care
• End of life decisions in the ICU
• The end of life care pathway
• Assessment and care planning for the dying patient
• Care after death and bereavement support
What are the challenges of end of life care in the critical care environment?
Communication and shared decision making

End of life discussions in ICU

• Limitations of/withholding treatment
• Withdrawal
• Brain stem death
• Admitted to ICU for dignified end of life care
• Where should death and withdrawal occur
• **DNAR (is it necessarily confined to end of life care?)**
• Organ donation
Communication and shared decision making

Discussions as the end of life approaches

• When discussions should occur
• Who should initiate the discussions – senior staff
• Open honest communication
• Identifying triggers for discussion
• Staff should be aware of the needs and preference of each individual
• What to do when you can’t contact family
• What is your role?
• Who to involve?
Withholding & withdrawing care

Withholding:

Treatment that is purposefully not initiated or limitation placed on existing therapy
Withholding & withdrawing care

• **Withdrawing:**
  • Treatment that has been initiated is stopped or gradually reduced.

• A clinical procedure requiring:
  • Thought
  • Careful individualised planning
  • Strong communication within MDT.
One Chance to Get it Right

• Leadership Alliance for Care of Dying People
  • 21 national organisations – GMC, RCN, DH, NHS England

• Focus on the needs and wishes of the dying person and those closest to them,

• 5 Priorities of Care
Priorities for Care of the Dying Person

The Priorities for Care are that, when it is thought that a person may die within the next few days or hours:

1. This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.

3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.
• Intranet
  – Palliative Care Home Page
## Limitation of Treatment Communication Sheet

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>MRN:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Lead:</td>
<td>Next of kin/contact details:</td>
<td></td>
</tr>
</tbody>
</table>

This document may be revised at any time if the clinical situation or wishes of the patient and/or family change. Please complete the review box on the back of this page.

Ensure you consider the following:
- Individualized patient care is the priority, which can be altered, amended or withdrawn at any time depending on the clinical situation.
- Every effort should be made to involve the patient in this process. The discussion with the patient and/or family regarding what is planned is documented (date:)

1. Full organ support is inappropriate as specified below (please tick):
   - Not for advanced respiratory support (including CPAP and NIV) □
   - OR □
   - Not for intubation and ventilation (but CPAP and NIV is permissible) □
   - Not for inotropes or vaspresors □
   - Maximum dose of vaspresors: dose: ____________
   - Not for renal replacement therapy □
   - Not for escalation above current treatment □ (please specify):

These limits of treatment do not exclude the use of medical management including hydration, feeding, antibiotic therapy and pharmaceutical management of illness.

2. Documentation

   Please document why limitation of treatment is appropriate (please continue on reverse if required):

   Please document the date, time and who were present at the conversation with the patient or the next kin:
   - Has a DNAR been discussed and completed? □
   - Have relevant members of the ICU team been informed of this decision? □ Names: ____________________________
   - The patient team are aware and are in concordance with this decision (if appropriate) □

Review of decision:
- Review Date (specific): ____________
- Review Interval (specify): daily □ every two days □ other: ____________
- Review if situation changes (specify and date): ____________
Withdrawal of Treatment Communication Sheet

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>MHN:</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

Recognition of the dying patient is difficult, especially in intensive care. Complete this document when a decision has been made between the senior members of the multi-disciplinary team and the patient and/or the patient’s next of kin to withdraw active treatment. Monitor for signs that may indicate an improvement in the clinical condition necessitating a review of this process.

1. Ensure you consider the following:
   - Every effort should be made to involve the patient in this process to individualise care. Discuss with the patient and/or family any particular requests regarding timing, environment or religious/spiritual beliefs and the possible duration of the dying process.
   - Consider palliative care referral
   - All patients should be assessed by the Specialist Nurse for Organ Donation (SNOD) who can be contacted via a 24 hr team paper, regarding the potential for tissue or organ donation.

2. Documentation
   Please document why withdrawal of treatment is appropriate (continue on separate sheet if needed):

   - Indicate that the following people have been involved and are in agreement regarding withdrawal of treatment (if appropriate):
     - Patient/Next of kin/family
     - Consultant of primary team
     - ICU multi-disciplinary team

3. Date and Time withdrawal of treatment is to commence:

4. Details of how withdrawal is to be conducted:
   - Leave current airway in situ
   - Wean to Room air
   - Turn of ventilator support
   - Maximum vasopressor/inotropic therapy to dose:
   - Wean/stop vasopressor/inotropic support (delete/specify below as appropriate)
   - Continue: Nutritional support (NG) and/or IV or SC maintenance fluids for hydration. Continue routine aspiration of NGT and prokinetics
   - Medication such as analgesics, anti-emetics, anti-secretory medicines and anti-emetics should be considered. Discontinuation of medications such as antibiotics, hypertensive medications, and anticoagulation may be appropriate
   - Remove all invasive lines if causing discomfort
   - Monitoring: silence all alarms and avoid non-invasive blood pressure monitoring
   - Ensure the patient and family are aware of the timing of withdrawal, the possible duration of the dying period and the methods of symptom management during this period.
   - Free text entry detailing process of treatment withdrawal.
**DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION**

Adults aged 16 years and over

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of DNA CPR order:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>/ /</td>
</tr>
<tr>
<td>Date of birth</td>
<td>DO NOT PHOTOYOPE</td>
</tr>
<tr>
<td>NHS or hospital number</td>
<td></td>
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</tbody>
</table>

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1. Does the patient have capacity to make and communicate decisions about CPR? If "YES" go to box 2
   If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition? If "YES" go to box 6
   If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? If "YES" they must be consulted.
   All other decisions must be made in the patient's best interests and comply with current law. Go to box 2

2. Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:

3. Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:

4. Summary of communication with patient's relatives or friends:

5. Names of members of multidisciplinary team contributing to this decision:

6. Healthcare professional completing this DNA CPR order:
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Time</td>
<td></td>
</tr>
</tbody>
</table>

7. Review and endorsement by most senior health professional:
   | Signature | Name | Date |
   | Review date (if appropriate) | |
   | Signature | Name | Date |
   | Signature | Name | Date |
Holistic assessment of a dying patient

Physical
Psychological
Spiritual, Religious
Cultural
Environmental

Other...... To include
Bladder
Bowel
Eye and mouth care
Turning as appropriate
Pain

Respiratory Tract Secretions

Nausea

Terminal Restlessness & Agitation
LAST OFFICES

STEP 1

Once the body has been washed and lines etc removed (as appropriate) please put a white sheet under the body and put the body in a Shroud.

*Ensure there are 2 name bands on the patient (ankle and wrist)*
LAST OFFICES

• **STEP 2**
  • Once the relatives have left and the body is ready to be removed, wrap the shrouded body in the white sheet.
  • *The reason for wrapping the body is to prevent skin deterioration by absorbing excess fluid*
LAST OFFICES

• **STEP 3**
  
  • If the body is leaking or is infectious, put the shrouded body, wrapped in the sheet, inside a body bag.

  • *Ensure a copy of the death notice is attached to the sheet or (if applicable) is in the plastic pouch on the body bag*
Summary

• The end of life is an important and challenging area of care

• Decisions in ICU can be complicated

• Provide an holistic assessment and care approach (physical, psychological, spiritual/religious, social, cultural and environment needs)

• Care and support after death and during bereavement
References:


http://www.dyingmatters.org/page/dying-matters-leaflets
Challenges of end of life care

- Support for family both during a person’s illness and into bereavement is often inadequate
- Relatively few adults discuss their own preference for care with close relatives/ friends, making it difficult for others to help ensure their wishes are met
- Health and social care staff find it difficult to initiate discussions with people/families
- After someone has died, problems may arise with: regards to verification and certification of death, viewing of the body and return of property to relatives

ALL CAN CAUSE DISTRESS TO THE BEREAVED