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Ethical Issues and Decision Making in Respiratory Care

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Introduction

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- In the United States, 1/5 people die in the ICU
- Ethical considerations, always inseparable from the practice of medicine, are often in conflict
- 20 years ago, the SUPPORT Study (The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments) showed that physicians offered life-sustaining treatments longer than they would have chosen for themselves
- Over the last several decades, with the advent of patient autonomy and shared decision making, the concerns of patients, clinicians, and society may also be in conflict
- Natural disasters and pandemics add another layer of complexity due to scarcity of resources
- Since most ethical dilemmas arise in patients who are dependent on ventilators, respiratory therapists need to understand the issues and should have a role in resolving them

Objectives

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- To know the ethical considerations in the ICU and respiratory care
- To understand the responsibilities and rights of the respiratory therapist in delivery of care, particularly end-of-life care
- To understand the ethical dilemmas during pandemics and natural disasters

Topics to be covered

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- The principles of bioethics
- Nonbeneficial or potentially inappropriate treatments
- Conscientious objection
- Shared decision making
- End of life care
- Allocation of scarce resources during pandemics or natural disasters

Ethical principles

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- In 1979, Beauchamp and Childress delineated 4 principles that should guide the ethical practice of medicine
  - Respect for autonomy
  - Beneficence
  - Non-maleficence
  - Justice
- These principles may be in conflict

Respect for autonomy

- The patients' right to self-determination
  - Making sure the patient (or surrogate) is as free as possible to make decision
  - In the past, healthcare providers adopted a very paternalistic approach, often undertaking (or withholding) extreme interventions without informing or getting consent of the patients
  - Does not absolve the provider from informing the patient of the pros and cons, nor of making a recommendation
  - Requires "respectful treatment in disclosing information"
    - Probing for and ensuring understanding and voluntariness, and fostering autonomous decision-making
- If a patient's refusal of an intervention is believed to result in harm to the patient, the provider should explore the reasons for the decision

Beneficence

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- Help patients whenever possible and do as much good as you can
  - Requires caregivers to be compassionate, empathetic and sensitive in their 'bedside manner'.
  - May clash with the principle of autonomy. If a patient has not consented to a procedure which could be in their best interests, what should a provider do?
- Per Beauchamp and Childress, autonomy can only be violated in the most extreme circumstances: when there is risk of serious and preventable harm
  - Or when decisions may harm others
  - There is debate about this

Nonmaleficence

- The Hippocratic Oath: “first do no harm”
- All medicine includes some risks and many interventions involve harming patient: surgeons cut people; prescriptions for medications often have harmful side-effects, etc.
- “”First do no harm” means avoiding anything which is *unnecessarily* or *unjustifiably* harmful
  - Does the benefit outweigh the harm?
  - Are there alternative treatments with equal benefit and less risk?

Justice

- Perhaps the most difficult of the principles to adhere by
- Distributive Justice involves the fair allocation of medical resources
  - Helps providers to determine which patients get priority when resources are scarce or when multiple patients need care simultaneously
- Procedural Justice concerns the fairness and the transparency of the processes by which decisions are made
  - The right to be treated equally and have equal access to treatment

Conscientious objection

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- In 2015, ATS policy statement regarding conscientious objection in the ICU
  - Reasons to accommodate conscientious objections include:
    - to protect clinicians' moral integrity
    - to respect clinicians' autonomy
    - to improve the quality of medical care
    - to identify needed changes in professional norms and practices.
  - Reasons not to accommodate conscientious objections include
    - to honor core professional commitments
      - Clinicians voluntarily commit to promote the patient's best medical interests, not to abandon the patient, and to make reasonable sacrifices for the benefit of their patient's health.
    - to protect vulnerable patients
    - to prevent excessive hardships for other clinicians or the institution to avoid invidious discrimination.

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Conscientious objection

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- Goal is to balance two ethical objectives
  - to protect patients' access to legal, professionally accepted, and otherwise available medical services
  - to protect clinicians' moral integrity

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Recommendations to balance ethical goals and conscientious objections

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- Conscientious objections in ICUs should be managed through institutional mechanism rather than ad hoc by clinicians
- Institutions should accommodate conscientious objections in ICUs if the following criteria are met:
  - the accommodation will not impede a patient's or surrogate's timely access to medical services or information
  - the accommodation will not create excessive hardships for other clinicians or the institution
  - the conscientious objection is not based on invidious discrimination
- A clinician's conscientious objection to providing potentially inappropriate or futile medical services should not be considered sufficient justification to unilaterally forgo the treatment against the objections of the patient or surrogate
  - Clinicians should use a fair process-based mechanism to resolve such disputes
- Institutions should promote open moral dialogue, advance measures to minimize moral distress, and generally foster a culture that respects diverse values in the critical care setting

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Example 1 (from the policy statement)

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- A 70-yr-old woman who suffered a large stroke has been in the ICU for 1 week on mechanical ventilation and has now developed sepsis from ventilator-associated pneumonia. The physician strongly recommends to the family a palliative treatment plan. The family disagrees but ultimately acquiesces after the physician firmly restates his recommendation. The physician asks the RT to extubate the patient as part of the palliative treatment plan. The RT is hesitant to extubate after witnessing the reluctance by the family but, due to a sense of powerlessness, says nothing and proceeds with extubation. The patient dies several hours later. The RT is very distressed that night, cannot sleep, and calls in "sick" to work the next day.

Example 1: ethical considerations and recommendations

- It is important both to prevent moral distress from occurring, as well as to manage moral distress that has occurred.
- In this case, the respiratory therapist has suffered moral distress from acting contrary to her moral compass.
- A perception of powerlessness prevented the RT from acting according to her moral beliefs.
  - The powerlessness may be real or perceived due to hierarchies in clinical care or other professional, institutional, legal, or cultural constraints.
  - It is essential to address the perceived powerlessness.
  - An open moral climate where all clinicians are encouraged to explore their moral concerns without fear of repercussions.
  - When moral distress has already occurred, the institution should provide support services (such as counseling) for clinicians

Example 2 (from policy statement)

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- A 25-yr-old woman is admitted to the ICU shortly after midnight with acute septic shock after a first trimester pregnancy termination. The attending ICU physician refuses to care for women whose critical illness is the result of an abortion, based on his religious beliefs.

Example 2: ethical considerations and recommendations

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- 1) the significant risk of immediate physical harm to the patient outweighs the risk of moral harm to the physician; 2) the provision of life-saving medical care is central to the role of the ICU physician; 3) the burden on institutions may be too high to ensure that there is always another provider available to accommodate conscientious objections in emergent situations
- In an acute life-threatening situation when a conscientious objection cannot be accommodated, the objecting clinician must provide the medical service to the patient or face institutional and legal sanctions.
- ICU clinicians with COs to certain life-saving medical interventions that are central to the critical care profession and for which a reasonable accommodation cannot be made, should not practice in a setting in which the conscientious objection will arise.

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Shared decision making

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- The concept of patient autonomy and shared decision making emerged in the latter half of the 20th century
- At the same time, we had the development of life-sustaining medical technologies that enabled the survival of patients who would have previously died
- More choices to make and more of a need to include patients and families in these decisions
- Conflicts most commonly emerge when patients and families request life-sustaining therapies that clinicians believe are inappropriate

Shared decision making

- "Shared decision making is a collaborative process that allows patients, or their surrogates, and clinicians to make healthcare decisions together, taking into account the best scientific evidence available, as well as the patient's values, goals, and preferences"
- Shared decision making puts the patient at the center of care
- Shared decision making should be used in establishing goals of care.
- Once goals of care are determined, the clinician has a responsibility to use experience and evidence-based practice to implement appropriate testing and treatment
  - The treatment team should explain what care is being given and why

Respiratory therapists and end-of-life care

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- The decision to withdraw ventilator support involves extensive discussion between the critical care team and patient or surrogates.
  - Patient's values and goals
  - Medical team's expert recommendations regarding the severity and expected prognosis of the illness.
- Though respiratory therapists are intimately involved with the care of ventilated patients and their families and are called upon for the removal of ventilatory support, they are very rarely involved in goals-of-care discussions.
  - 93.8% participate in a terminal extubations,
  - 12.3% speak directly with the patient and/or family about end-of-life care
  - 10.8% participate in a multidisciplinary team that discusses end-of-life care
  - 29.2% are comfortable with end-of-life discussions with the patient and/or family
- RTs may be more likely to experience emotional and/or moral distress
- RTs have a valuable role in comforting and educating the family

Survey of 173 RTs, 63 Responded

Respir Care 2016;61(7):891–896

What is moral distress?

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- Healthcare professional moral distress:
  - When a healthcare professional (who has taken an oath to serve the good of the patient) believes he or she knows the ethically correct action, but is unable due to interpersonal (with colleagues, patients, or families) institutional, regulatory, or legal constraints
  - Most of the research is on nurses
  - A study done at Baylor Health Care System showed that moral distress was high across multiple healthcare disciplines, including respiratory therapists

J Clin Ethics. 2013 Summer;24(2):98-112

Moral distress survey

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Clinical scenario: all professionals	Intensity of of distress 0 1 2 3 4 5 6	Frequency of distress 0 1 2 3 4 5 6
I follow the patient's wishes for treatment even when I do not think it is the right thing to do.		
I follow the family's wishes for patient treatment when I do not think it is the right thing to do.		
I participate in starting or maintaining life-sustaining treatments when I do not think it is right to start or maintain such treatment.		
I participate in withdrawing or withholding life-sustaining treatments when I do not think it is right to stop such treatment.		
I participate in the discharge of patients who I do not believe are medically ready for discharge.		
I participate in the discharge of patients into circumstances of inadequate social support.		
I provide different treatment for those who can afford to pay or have insurance than for those who lack insurance or cannot pay.		
I provide better treatment for U.S. citizens, regardless of the ability to pay, than I provide for undocumented immigrants.		
I participate in hiding information, especially bad news, from patients because of family requests.		

J Clin Ethics. 2013 Summer;24(2):98-112

Moral distress survey, continued

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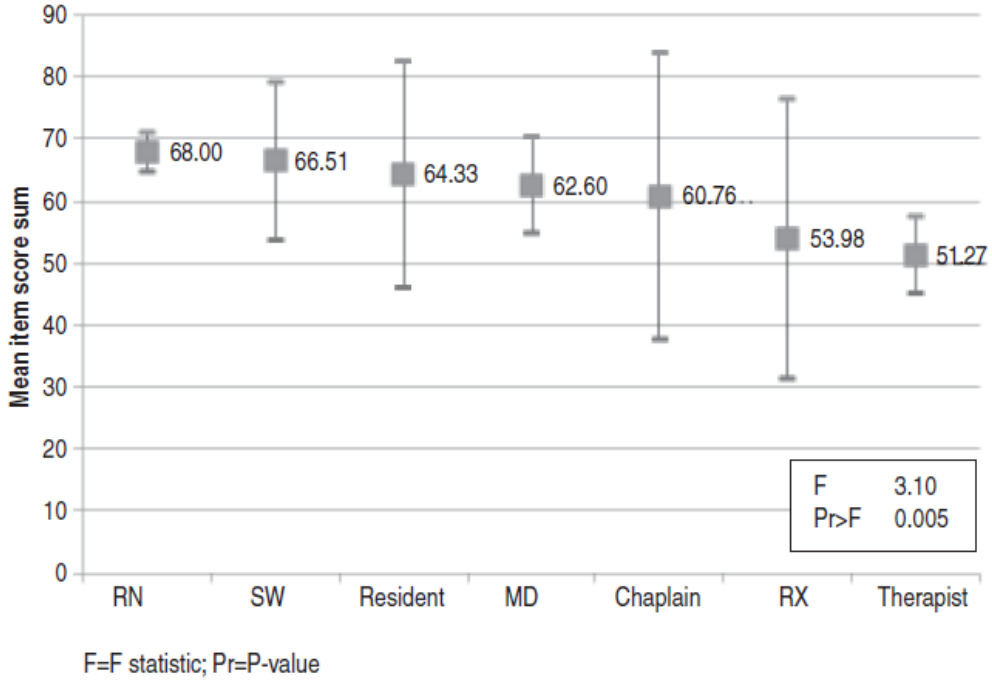
Clinical scenario: RNs and other therapists (PTs, OTs, STs, RTs, nutritionists, pharmacists)
I carry out orders for tests or treatment that I do not believe are in the interest of the patient.
I assist a physician who performs a test or treatment without informed consent.
I ignore situations in which patients or families have not been given adequate information to insure informed consent.
I carry out work assignments for which I do not feel adequately trained.
I work with levels of staffing that I consider unsafe.
I observe without taking action when patients have poorly treated pain.
I provide treatment that does not relieve the patient's suffering because I fear increasing doses of pain medication will harm the patient.
I provide treatment that does not relieve the patient's suffering because the physician fears increasing doses of pain medication will harm the patient.
I observe without taking action when healthcare personnel do not respect patient privacy.
I follow physician or family orders not to disclose information to patients, even when I believe the patient is competent.
I participate in the treatment of demented patients who have had a G-tube inserted that I believe may not have been in the patient's best interest.
I participate in the discharge of patients who I do not believe are ready for discharge.

J Clin Ethics. 2013 Summer;24(2):98-112

Figure 3. Mean moral distress score by job role, with 95 % confidence interval



F=F statistic; Pr=P-value

Nonbeneficial or potentially inappropriate treatments

- Bring into conflict interests of patients, clinicians, and society
  - "Patients have an interest in receiving care consistent with their values and preferences"
  - "Clinicians have an interest in not being compelled to act against their best understanding of their professional obligations"
  - "Society has important interests in protecting individual rights, fostering clinician professionalism, and ensuring the fair allocation of medical resources."
- Patients are generally incapacitated and have little choice regarding their treating clinicians, and have limited ability to seek treatment elsewhere
- These conflicts are very common in the ICU
  - Physicians report that they provide nonbeneficial care about 20% of the time

Am J Respir Crit Care Med Vol 191, Iss 11, pp 1318–1330, Jun 1, 2015

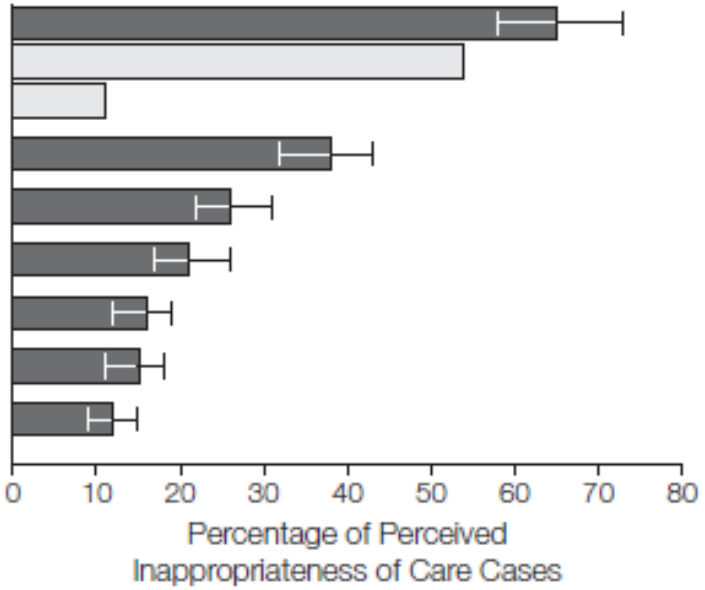
Impact on healthcare workers

- ICU clinicians commonly report providing care in conflict with their personal and professional beliefs.
- They may be uncomfortable discussing options that are contrary to their beliefs: e.g., withholding feeding
- In a recent survey of ICU clinicians (82 ICUs, 1651 clinicians), 27% of respondents reported acting “in a manner contrary to his or her personal and professional beliefs” during the single-day study period
- Most common: providing treatment perceived to be excessive or overly aggressive
- A survey of 504 European ICU physicians showed that 73% of units frequently admitted patients with no realistic hope of survival
- 87% of 114 Canadian ICU physician directors reported that futile care was provided in their ICU over the last year

JAMA 2011;306:2694–2703

Figure 3. Reasons and Rates of Perceived Inappropriateness of Care Reported by Clinicians

Reason	No. of Cases
Disproportionate care	290
Too much care	
Too little care	
Other patients would benefit more	168
Lack of participation in decision making	118
Persistent nonadherence of patient	96
Inaccurate information to patient or family	70
Not good quality care	64
Disregarding patient's wishes	52



JAMA 2011;306:2694–2703

Futile vs potentially inappropriate care

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- The term “futile” should only be used in the rare situation when the intervention will not accomplish the intended physiologic goal. Clinicians should not provide futile interventions and should explain why
  - Value judgments are not a factor in the decision
  - Examples:
    - Performing CPR in a patient who had remained severely hypoxemic on 100% FiO2/high PEEP and severely hypotensive on maximum vasopressors
    - Performing CPR in a patient with a myocardial rupture
- The term “potentially inappropriate” should be used when the intervention has at least some chance of accomplishing the intended effect, but clinicians believe that competing ethical considerations justify not providing them
  - Necessarily involves value judgments
  - Examples:
    - Performing a tracheostomy in a patient with severe, irreversible (but survivable) brain injury
    - ICU admission for a person with end-stage dementia and multiorgan failure
  - Most conflicts are resolved with intensive communication; discussions regarding goals of care

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Futile care is uncommon

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- It is uncommon for surrogates to request treatments that are futile
- "Short of brain death, there are no criteria or rules to which clinicians can appeal to justify decisions to refuse life support, at least when those treatments hold even a small chance of achieving the patient's goals"
- Clinicians vary in their attitudes/beliefs about what treatments should be offered near the end of life

JAMA Intern Med. 2013; 173(20):1894-1895

If conflicts cannot be resolved . . .

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- Clinicians should try to understand the surrogate's perspective, correct misperceptions and misunderstandings, and share their perspectives with the surrogate.
- If the surrogate continues to advocate for treatments that the clinician believes are inappropriate, the clinician should respectfully advocate for an alternative treatment course
- Palliative Care consultation can be helpful
- Obtain second opinion
- If available, request review by an interdisciplinary hospital committee (Ethics Committee, Palliative Care, legal, pastoral care, etc)
- Offer surrogates the opportunity to transfer the patient to another institution
- If disputes persist, inform surrogates of the opportunity to pursue extramural appeal

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Why should clinicians refrain from providing nonbeneficial care?

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- It violates 2 ethical principles
  - Beneficence – to benefit individual patients
  - Maleficence – to first do no harm
- It also may violate a clinician's obligation to steward medical resources responsibly
- Cost

Withhold vs withdrawing life support

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- Most patients who die in intensive care units (ICUs) in the United States do so during the withholding and withdrawal of life support
- There is no ethical difference between withholding or withdrawing life supporting treatment
  - A patient has the right to refuse treatment even if it would result in death
  - A physician may not administer an intervention with the purpose of causing death (i.e., euthanasia)
- Respiratory therapists have an important role in preparing and comforting patients and their families when support is withheld or withdrawn

The principle of double effect

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- Distinguishes between intended and unforeseen or unintended effects or consequences
- Consensus exists (ethical and religious) in the standard treatment of pain at the end of life
  - The Catechism of the Catholic Church states, “Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such, it should be encouraged”
- At the end of life, sedatives and analgesics that lead to the relief of pain, are permissible even if they hasten death, provided that only the good effect is intended. The morally bad effect may be foreseen, but it may not be intended
  - The risk does not outweigh the benefit
  - The risk of respiratory depression when administering opioids appropriately for relief of pain or dyspnea is very low
- The bad effect also may not be a means to the good effect*, and the good effect must outweigh the bad one; that is, risking death is reasonable in palliating a terminally ill patient only if there are no less risky ways of relieving suffering.
  - * the double effect is distinct from euthanasia

Catechism of the Catholic Church. 1994. Part Three, Life in Christ, Section 2, Chapter 2, Article 5

The allocation of scare medical resources (ASMR) during pandemics or national disasters

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A shift in our ethical famework

- What if we should insufficient life-sustaining resources to care for all patients who might benefit from them?
- Shift from a conventional individual patient-focused duty of care to a more community-focused duty of care with goals of maximizing the number of patients who survive (both short and long -term)
- A clear, fair, transparent and efficient plan for the allocation of scarce medical resources grounded in a variety of ethical obligations, including duty to care, duty to steward resources, and duties stemming from distributive and procedural justice.

ASMR principles

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- All factors utilized for resource allocation must be based on specific, objective medical evidence
- Must not take into account any patient's race, color, national origin, disability, age, sex, exercise of conscience, and religion
- No medical judgments will be made with stereotypes, assessments of quality of life, and judgments about a person's relative "worth."
- Only goes into affect when resources are overwhelmed

Challenges in drafting and implementing plan

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- Unintended biases
  - Penalizing patients who have a shorter life-expectancy due to chronic co-morbid conditions that arose or worsened due to social inequities
  - Including long-term survivability as a factor introduces biases
- No patients should be categorically excluded from receiving life-sustaining care

The allocation of scare medical resources (ASMR) during pandemics or national disasters:

Ethical Framework

- Fairness
  - An overarching goal in developing crisis standards of care (CSC) protocols is for them to be recognized as fair by all affected parties
  - Policies should reflect awareness of existing disparities in access to care, take account of the needs of the most vulnerable, and support the equitable and just distribution of scarce goods and resources
- Duty to Care
  - Beneficence
  - Health care professionals have a duty to care for the individual patient
- Duty to Steward Resources
  - Healthcare institutions and public health officials have a duty to steward resources in order to provide the most good to the most people
  - Healthcare providers caring for individual patients should not be involved in the triage process
- Transparency
  - The public should be engaged to engender and preserve trust in the CSC protocols
- Consistency
  - Treating like groups alike
  - Protocols should be consistent across institutions
- Proportionality
  - Limits on the allocation of resources should be commensurate with the burden and with the available resources
- Accountability
  - Individuals at all levels of the healthcare system
  - Essential for building and maintaining trust

Splitting ventilators

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- The Society of Critical Care Medicine (SCCM), American Association for Respiratory Care (AARC), American Society of Anesthesiologists (ASA), Anesthesia Patient Safety Foundation (ASPF), American Association of Critical-Care Nurses (AACN), and American College of Chest Physicians (CHEST) issue a consensus statement on the concept of placing multiple patients on a single mechanical ventilator
- It should not be attempted because it cannot be done safely with current equipment
  - There are multiple physiologic and mechanical risks
- If the ventilator can be lifesaving for a single individual, using it on more than one patient at a time risks life-threatening treatment failure for all of them

CPR and airway emergencies in patients with COVID-19 or other potentially fatal infections:

Ethical considerations

- It is essential that providers protect themselves and their colleagues from unnecessary exposure
  - Exposed providers who contract COVID-19 further decrease the already strained workforce available to respond and have the potential to add additional strain if they become critically ill
  - Even if it delays care, before entering the scene, all rescuers should don appropriate PPE
- Potentially inappropriate treatment
  - The calculation may change if the treatment puts caregivers at additional risk
  - The resuscitative effort may divert rescuer attention away from other patients
    - Resources may be severely limited

In conclusion . . .

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- Ethical considerations and conflicts are common in the ICU
- Respiratory therapists have a central role in the care of patients requiring life-supporting therapies or nearing the end of life and are at risk for moral distress
- During times when resources are scarce, such as pandemics or national disasters, the ethical framework shifts from a focus on the individual to the many
- During these times, we must be cognizant of unintended consequences in the way we allocate resources